GENERAL DEFINITIONS (Continued)

Conditions which:
- exist and are treated at the same time; or
- are due to the same or related causes;

are considered to be one **Illness**. LTD3a

If state law so requires, **Illness** will include any congenital defect of a newborn child.

- **"Insurance Carrier"** means a provider of any of the following types of plans:
  - a group or group type health insurance policy or plan; or
  - a prepayment subscriber contract such as Blue Cross/Blue Shield; or
  - a plan which is provided by a Health Maintenance Organization.

- **"Insured Person"** means you and those of your **Dependents** who are covered under this **Booklet.**

- **"Intensive Care Unit"** means a ward in a **Hospital** which meets all of the requirements shown below. It must:
  - be designated by the **Hospital** as an **Intensive Care Unit.**
  - be maintained on a 24 hour basis.
  - be operated solely for the care of the acutely ill.
  - be equipped to provide special nursing and medical services. Such services must not be available in the **Hospital's:**
    - surgical recovery rooms; or
    - semi-private rooms; or
    - private rooms; or
    - wards.
  - not be chiefly a place for private duty nursing care.

  The patient's confinement must depend on his need for **all** of the Unit's services.

- **"Medically Necessary"** means any services and supplies provided for the diagnosis and treatment of a specific illness, injury or condition must be:
  - ordered by a **Doctor**; and
  - required for the treatment or management of a medical symptom or condition; and
  - the most efficient and economical service which can safely be provided to such person; and
  - provided in accordance with approved and generally accepted medical or surgical practice.

  We may require proof in writing satisfactory to **us** that any type of treatment, service or supply received is **Medically Necessary**. Medical necessity will be determined solely by **us.** The fact that a **Doctor** may prescribe, order, recommend or approve a service does not, in itself, make such service or supply **Medically Necessary.**

  Medical necessity does not include any:
  - repeated test which is not necessary; or
  - experimental treatment, service or supply; or
  - service or supply which is for the psychological support, education or vocational training of the **Covered Person**; or
  - implant of any artificial organ for any reason whatsoever.

GENERAL DEFINITIONS (Continued)

- **"Medicare"** means Title 18 of the United States Social Security Act of 1965 as amended from time to time. **"Medicare Benefits"** means the coverage provided under Title 18.

- **"Monthly Earnings"** means your monthly pay received from your **Employer** in effect just prior to the date you become **Totally Disabled.** This does not include:
  - overtime or bonuses; or
  - earnings from other employers;

  but it does include commissions. As used herein, "commissions" means your average monthly commissions during the preceding 12 month period, or during your period of employment if less than 12 months.

- **"Period of Disability"** means that period which:
  - starts with the date you are first absent from **Work** as a result of **Total Disability**; and
  - lasts for at least the length of the **Elimination Period.**

  Successive **Periods of Disability** will be considered as one period unless:
  - you complete at least 6 months of continuous **Service** before the later disability starts; or
  - if the later disability is due to causes wholly different from those of the prior disability, you complete at least one day of **Work** before the later disability starts.

  "Service" as used above does not include any period during which you receive Long Term Disability benefits.

- **"Pre-admission Testing"** means diagnostic laboratory and x-ray tests which are:
  - performed in a clinic or the out-patient department of a **Hospital:**
    * for a condition for which an in-patient confinement has been scheduled; and
    * in place of tests that would normally have been performed during the scheduled in-patient confinement. These tests must be accepted as such by the **Hospital** concerned; and
    * within 7 days of the scheduled in-patient confinement;

  and
  - prescribed by the **Doctor** who:
    * scheduled the in-patient confinement; or
    * attends the patient during such confinement.

- **"Proceeds"** means the amount of life insurance benefits payable under this **Booklet.** L3

- **"Proof of Good Health"** means written evidence that the person is in good health according to **our** general standards. Such evidence includes but is not limited to medical evidence.

- **"Retired Employee"** means:
  - a retired salaried **Employee** who has attained age 65; or
  - a retired salaried **Employee** who was covered under the Medical Expense Reimbursement Benefit Plan prior to retirement, and who has 15 or more years of service or is under the **Employer's** formal pension plan.

GENERAL DEFINITIONS (Continued)

Note: All Retired Employees as defined above are eligible for Life Insurance. They are not eligible for Accidental Death, Dismemberment and Loss of Sight (AD&D) benefits or Long Term Disability Insurance.

Only salaried Retired **Employees** who were covered under the Medical Expense Reimbursement Benefit Plan prior to retirement are eligible for Hospital, Medical, Dental and Vision coverage.

- **"Service"** means **Work** with the **Employer**:
  - on an active, permanent, full-time and full pay basis; and
  - for at least 30.00 hours per week.

  For a **Retired Employee**, **"Service"** means the period during which he is retired in accordance with the definition of **"Retired Employee"** as described above. L3

- **"Skilled Nursing Facility"** means an institution, or distinct part of one, which meets all of the requirements shown below. It must:
  - have a transfer agreement with at least one **Hospital** as defined herein.
  - chiefly provide:
    * 24 hour skilled nursing care; and
    * rehabilitation services for the treatment of injured, disabled or sick persons.
  - have policies which are developed and reviewed by a group of professionals which includes at least one **Doctor.**
  - have a **Doctor,** registered nurse or medical staff who are responsible for enforcing such policies.
  - require that a **Doctor** supervise the health care of each patient.
  - have a **Doctor** available at all times.
  - keep clinical records on all patients.
  - employ at least one registered nurse full-time.
  - provide facilities for dispensing and administering drugs.
  - be legally licensed by the state of location.
  - have a utilization review plan.
  - not be chiefly a place for the aged, alcoholics, drug addicts, the mentally ill or the retarded.
  - not be a place for **Custodial Care.**

- **"Totally Disabled"** and **"Total Disability"** mean being under the care of a **Doctor** and prevented by **Illness**:
  - in your case, from performing your regular **Work**; and
  - in the case of your **Dependent,** from engaging in substantially all of the normal activities of a person of the same age and sex who is in good health.

  Note: For LTD benefits, refer to the LTD Section of this **Booklet** for a special definition of **Total Disability.**

- Unless otherwise defined in any Benefit Provision, **"Usual and Customary Charges"** means charges for **Medically Necessary** services and supplies which would usually be provided for cases the same as or similar to the one being treated. The **Usual and Customary Charge** is limited to the lesser of:
  - the fee usually charged by the provider for similar services and supplies; and
  - the fee usually charged for the same service or supply by other providers who are in the same area.

    "Area" means a geographical area as determined by **us** to be significant enough to establish a representative base of charge for the treatment.

GENERAL DEFINITIONS (Continued)

If a **Covered Person** is confined in a **Hospital** in a state that requires the use of a DRG Reimbursement System, then the DRG Reimbursement System for that state will be used to determine the **Usual and Customary Charges**. This means:

- payment for a **Hospital** confinement as a registered bed-patient which meets the length of stay standards set up under the DRG system for the state in question will be made according to the regulations approved for the DRG system in that state.
- **we** will not pay more than the price per case set for the condition in the DRG schedule of rates in the state in question.

- **"We"**, **"our"** and **"us"** will be used in reference to:
  - for **Health Benefits**, the **Employer**; and
  - for all other benefits, New England Mutual Life Insurance Company. (TNE)L3a, (TNE)LTD3c

- **"Work"** means **Service** with your **Employer**. In any Benefit Provision where a 2-week return to **Work** condition is used to determine a new Benefit Period for an **Employee**, a **Retired Employee** will be treated in the same way as a **Dependent** of an active **Employee**.

- **"You"** and **"your"** will be used in reference to the **Employee**. L3a, LTD3c

HEALTH BENEFITS

Employee Health Care Payment Plan
For Employees of

BUS ASSOCIATES, INC.

This **Booklet** becomes your Proof of Coverage only if:

- you are eligible for coverage (see WHO'S ELIGIBLE section);
- you become covered by filling out the appropriate application forms and by being approved for coverage by your **Employer**;
- you stay covered; and
- an Identification Card is issued to you by your **Employer**.

MEDICAL MANAGEMENT PROVISION

Subject to all other provisions of this **Booklet**, Medical Management will review each proposed **Hospital** admission, and each proposed surgical procedure which is to be performed outside the **Doctor's** office (excluding minor first aid). Medical Management will then determine and authorize:

- the medical necessity of such treatment;
- the appropriate location for such treatment to be provided; and
- in the case of a **Hospital** admission, the length of stay for each in-patient **Hospital** confinement.

To reach Medical Management, call the toll-free Member Services number printed on your ID card. Medical Management must be contacted:

- in advance of treatment being rendered; or
- in the case of an emergency, within 48 hours of the date the emergency treatment begins. The term "emergency" means:
  - an accident which requires immediate treatment; or
  - a "life threatening" illness which requires immediate treatment at a **Hospital**. The **Doctor** who attends the **Covered Person** must certify that the illness was "life threatening".
- in the case of pregnancy, Medical Management pre-authorization is not required. This **Booklet** provides coverage for:
  - a normal vaginal delivery, for a minimum 48-hour **Hospital** stay for you and your baby.
  - a caesarean section, for a minimum 96-hour **Hospital** stay for you and your baby.

  A **Hospital** stay may be less than the 48-hour or 96-hour minimum if a decision for an early discharge is made by the attending physician in consultation with the mother.

If:

- Medical Management is contacted as described above, but the **Covered Person** does not follow the Medical Management authorization; or
- Medical Management is not contacted as described above;

then expenses related to a **Hospital** admission or out-patient surgery (excluding minor first aid) will be subject to the Medical Management Deductible. The Medical Management Deductible:

- is in addition to any other deductible under this **Booklet**; and
- will not be used to satisfy any Break Point; and
- is shown in the Table of Benefits.

MEDICAL MANAGEMENT PROVISION (Continued)

If:

- Medical Management is contacted as described above, but the **Covered Person** does not follow the Medical Management authorization; or
- Medical Management is not contacted as described above;

then the claim may be reviewed by Medical Management after it is received by **us** to determine which expenses, if any, are not eligible for payment under this **Booklet.**

MAXIMUM BENEFIT REDUCTION

The Medical Management Deductible is applied to reduce the benefits payable under this **Booklet.** In no event will the application of such reduction result in payment of less:

- **Hospital Covered Expenses,** 50%;
- all other covered expenses, 60%

of the amount which otherwise would have been payable for such benefits.

ALTERNATE CARE AND TREATMENT

Alternate forms of care and treatment may be recommended by Medical Management as part of its Prior Authorization or Catastrophic Claims Management (CCM) programs. Medical Management may, from time to time, recommend the use of alternate treatment plans or alternate treatment facilities such as **Home Health Care** or **Hospice Care** which:

- are not included in this **Booklet**; or
- are included in this **Booklet** but on a basis that differs from the care and treatment now recommended by Medical Management.

When this happens, subject to approval of the **Covered Person** and his:

- family; and
- attending **Doctor**;

these expenses will be payable under this **Booklet** on the same basis as the care and treatment for which they are substituted. This means they will count toward the Maximum Lifetime Benefit described in the Plan Maximum Amount section of this **Booklet.**

AUTHORITY AND LIABILITY

It is understood and agreed that **we** will have the authority to implement the alternate forms of care and treatment recommended by Medical Management without obtaining prior consent of the **Employer.**

This may include the incurral of costs or expenses which are not covered in whole or in part by this **Booklet.** Such expenses will be considered as:

- expenses covered under this **Booklet**; and
- chargeable to this **Booklet** as claims.

COMPREHENSIVE/MAJOR MEDICAL EXPENSE BENEFITS (C/MM)

QUALIFICATION FOR BENEFITS

If, as a result of **Illness**, a **Covered Person** incurs **Covered Expenses** then **we** will pay benefits in accordance with the **C/MM** Benefits section below.

Benefits will be paid only if the **Covered Expenses** are:

- for services and supplies that are:
  - **Medically Necessary**; and
  - recommended, performed or prescribed by a **Doctor**; and
- incurred while the **Covered Person** is covered under this Benefit Provision.

C/MM BENEFITS

We will pay benefits for all **Covered Expenses** for each **Covered Person** in each calendar year as follows:

Cost Effective Services - 100% Services

The following **Covered Expenses** will be payable at 100% of **Usual and Customary Charges** with no Deductible.

- **Pre-admission Testing**.
- Facility charges for treatment in a child-birth center.
- Medical Management Directed Second Opinions.
- **Home Health Care Covered Expenses.**
- Confinement in a **Skilled Nursing Facility.**
- Out-patient surgery performed in:
  - the out-patient department of a **Hospital**;
  - an Ambulatory Surgical Center.
- **Preventive Care Covered Expenses.**

COMPREHENSIVE/MAJOR MEDICAL EXPENSE BENEFITS (C/MM) (Continued)

Network Services - Services rendered in a New England PPO Hospital or by a New England PPO Physician

"New England PPO Hospital" and "New England PPO Physician" mean any facility or **Doctor** which has been selected by **us** and whose name is published and given to you.

The following **Covered Expenses** will be payable at 100% of **Usual and Customary Charges** with no Deductible:

- **Hospital Covered Expenses** incurred in a New England PPO Hospital for:
  - In-patient Care.
  - All out-patient Care (except out-patient surgery).
- expenses for services other than office visits rendered by a New England PPO Physician.

After a **Covered Person** has satisfied the New England PPO Physician's Office Visit Co-Pay Amount of $10.00, expenses for services (except surgery) rendered in the office of a New England PPO Physician will be payable at 100% of **Usual and Customary Charges** with no Deductible. The New England PPO Physician's Office Visit Co-Pay Amount will apply to each office visit.

The following services of a Non-New England PPO Physician will be covered on the same basis as services of a New England PPO Physician:

- radiology and pathology when services are provided in a New England PPO Hospital;
- radiology and pathology upon referral by a New England PPO Physician when services are provided out-of-Hospital;
- anesthesiology and assistant surgery when services are provided in a New England PPO Hospital and the surgery is performed by a New England PPO Physician;
- inpatient **Hospital** consultations in a New England PPO **Hospital** by a non-New England PPO specialist, if a New England **Physician** refers the patient to a specialist.

Non-Network Services - Services rendered in a Non-New England PPO Hospital or by a Non-New England PPO Physician

The following **Covered Expenses** will be payable at a Percentage of 80% after the **Covered Person** has satisfied the Deductible Amount:

- **Hospital Covered Expenses** incurred in a Non-New England PPO Hospital for:
  - In-patient Care.
  - All out-patient Care (except out-patient surgery).
- expenses for services rendered by a Non-New England PPO Physician.

COMPREHENSIVE/MAJOR MEDICAL EXPENSE BENEFITS (C/MM) (Continued)

Other Services

All other **Covered Expenses** are considered Other Services. Other Services include:

- **Spinal Adjustment and Treatment Covered Expenses** whether the the provider of service is a New England or a Non-New England PPO Physician.

We will pay benefits for Other Services for each **Covered Person** in each calendar year which exceed the Deductible Amount at a Percentage of 80%.

Break Point

The following applies to all **Covered Expenses** except those which are payable at 100%.

Benefits will be paid at the applicable Percentage only until the amount of such **Covered Expenses** equals the Individual Break Point. Once the Individual Break Point for a **Covered Person** has been reached, benefits for **Covered Expenses** incurred by that person during the rest of that calendar year will be paid at 100%.

Covered Expenses used to satisfy any Deductible or Co-Pay Amounts will not be used to satisfy the Individual Break Point.

The Individual Break Point for each **Covered Person** in any calendar year will be reduced by the amount of **Covered Expenses**:

- which were incurred in the last 3 months of the previous calendar year; and
- to which the Percentage was applied in calculating benefits.

If in any one calendar year **Covered Expenses** for your family are equal to or greater than the Family Break Point shown in the Table of Benefits, excluding **Covered Expenses** used to satisfy any Deductible or Co-Pay Amounts, then the **Covered Expenses** of all family members incurred during the rest of that calendar year will be payable at 100%.

DEFINITIONS

- "**Covered Expenses**" means the following types of expenses:
  - **Hospital Covered Expenses;**
  - **Medical Covered Expenses;**
  - **Dental Covered Expenses;**
  - **Spinal Adjustment and Treatment Covered Expenses;**
  - **Preventive Care Covered Expenses;**
  - **Well Newborn Care Covered Expenses;**
  - **Home Health Care Covered Expenses;**

  Only the **Usual and Customary Charge** for a service or supply is a **Covered Expense.**

  Covered Expenses are considered to be incurred on the date the service was rendered or the supply is provided.

COMPREHENSIVE/MAJOR MEDICAL EXPENSE BENEFITS (C/MM) (Continued)

- **"Hospital Covered Expenses"** means:
  - charges by a **Hospital** for the services and supplies listed below when they are provided during confinement as an in-patient:
    * room and board. For each day of confinement, the **Covered Expense** is limited to the usual charge of the **Hospital** concerned for semi-private care.
    * confinement in an **Intensive Care Unit.** For each day of confinement, the **Covered Expense** is limited to the usual charge of the **Hospital** concerned for confinement in an **Intensive Care Unit.** This amount is for room and board only and will not include charges for nursing services.
    * **Hospital** Extras.
  - charges by a **Skilled Nursing Facility** for an **Eligible Skilled Nursing Facility Confinement**, up to:
    * for each day of confinement, the usual charge of the facility concerned for semi-private confinement in a **Skilled Nursing Facility.** This may not exceed 1.5 times the Hospital Daily Amount for confinement in the last **Hospital** in which the patient was confined before his admission to the **Skilled Nursing Facility.**
    * for all days of **Eligible Skilled Nursing Facility Confinement**, 90 days.
  - charges by a **Hospital** for services and supplies provided during treatment as an out-patient.

- **"Medical Covered Expenses"** means charges for the services and supplies listed below:
  - services of a **Doctor.** This does not include:
    * dental treatment except when considered a **Dental Covered Expense;** or
    * psychiatric treatment or psychotherapy except when rendered during **Hospital** confinement.
  - anesthetics and their administration.
  - diagnostic x-ray and laboratory procedures. Dental x-rays are covered only when they are taken in conjunction with dental treatment considered as a **Dental Covered Expense.**
  - treatment by x-ray, radium and radio-active isotopes.
  - oxygen and its administration.
  - blood transfusions. This includes the cost of blood.
  - services of registered nurses and licensed practical nurses. This does not include:
    * members of your family or your **Dependent's** family; or
    * the regular nursing staff of any **Hospital** in which the patient is confined.
  - services of licensed physical therapists other than members of your family or your **Dependent's** family.
  - allergy serums, insulin syringe and clinitest.
  - professional ambulance services.
  - rental of a wheelchair, bed rail, hospital bed or iron lung.
  - splints, trusses, orthopedic braces, crutches, casts, artificial eyes.
  - purchase, repair and replacement of artificial limbs. That part of the charge which exceeds the cost of the least expensive functional limb available will not be considered a **Covered Expense.**
  - occupational and speech therapy while confined in a **Hospital.**
  - head halter, traction apparatus.
  - cervical collar, colostomy bag, ileostomy supplies and catheters.
  - any prosthetic device required as a result of a mastectomy.
  - out-of-**Hospital** services of licensed speech, hearing and occupational therapists other than members of your family.
  - an annual cytologic screening (Pap smear and pelvic exam) for women age 18 or over, whether or not required as a result of symptoms of **Illness;** and

COMPREHENSIVE/MAJOR MEDICAL EXPENSE BENEFITS (C/MM) (Continued)

- mammography, whether or not required as a result of symptoms of **Illness**. This includes
  * a mammogram at any age, if recommended by the **Covered Person's Doctor**, for women who:
    - have had a prior history of breast cancer; or
    - whose mother or sister have had a prior history of breast cancer;
  * a single baseline mammogram for women age 35 through 39 inclusive;
  * a mammogram every 2 years, or more frequently if recommended by the **Covered Person's Doctor**, for women age 40 through 49; and
  * an annual mammogram for women age 50 or over.
  * medically approved formulas for the treatment of phenylketonuria (PKU), branched-chain ketonuria, galactosemia, and homocystinuria.

- **"Dental Covered Expenses"** means charges by a **Doctor, Dentist** or **Oral Surgeon** for:
  - treatment of:
    * a fractured jaw; or
    * **Accidental Injuries** to natural teeth within 12 months after the accident.
  - alveoloplasty or alveolectomy. This applies only to an area occupied by not less than 6 teeth per jaw.
  - treatment of cellulitis.
  - excision of soft tissue lesion of oral cavity.
  - biopsy.
  - excision of tori.
  - excision of benign hard tumor (osteoma), radicular or dentigerous cyst.
  - closure of oro-antral fistula.
  - removal of salivary stone from duct or gland.
  - therapeutic nerve block with alcohol or other sclerosing solutions.
  - surgical removal of impacted teeth.
  - treatment of Temporomandibular Dysfunction (TMJ). For the purposes of this **Booklet**, TMJ is considered to mean craniofacial muscle disorders and temporomandibular disorders.

    TMJ treatment includes but is not limited to:
    * **Hospital** care;
    * surgery;
    * exams and diagnostic x-rays;
    * muscle injections;
    * nerve block injections;
    * manipulation under anesthesia;
    * grinding the surface of the teeth;
    * splints and appliances;
    * orthodontic treatment such as braces or wires;
    * change of vertical dimension including crowns;
    * jaw tracking; and
    * drug therapy.

COMPREHENSIVE/MAJOR MEDICAL EXPENSE BENEFITS (C/MM) (Continued)

No amount will be paid for:
* electromyography;
* sonography;
* thermography;
* study models;
* dietary and related biochemical analysis; or
* dental kinesiology.

- **"Spinal Adjustment and Treatment Covered Expenses"** means charges incurred for services related to the adjustment of the spine. This excludes massage.

- **"Preventive Care Covered Expenses"** means charges for **Preventive Care.** Payment for such expenses for any one **Covered Person** in each calendar year will not exceed $300.00.

  "Preventive Care" means, for a **Covered Person** who is at least 8 days of age:
  - a physical examination of the heart, lungs and abdomen by a **Doctor**;
  - such diagnostic services as may be required as part of such exam;
  - necessary immunizations and booster shots;
  - routine pelvic exams and Pap smears;
  - mammography for women age 18 through 34; and
  - an evaluation of the **Covered Person's** general health status by his primary **Doctor**;

  when such services are not required as a result of symptoms of **Illness.**

- **"Well Newborn Care Covered Expenses"** means:
  - routine nursery charges;
  - charges for **Doctor's** fees for an examination; and
  - charges for circumcision;

  for a well newborn infant through the first 7 days of its life.

- **"Home Health Care Covered Expenses"** means charges incurred for the services and supplies provided by a Home Health Care Agency to a **Covered Person** at his place of residence. In no event will a nursing home be considered a **Covered Person's** place of residence.

  The Home Health Care Agency must be:
  - certified under Title XVIII of the United States Social Security Act of 1965 as amended from time to time; or
  - licensed by the state licensing body or approved by the department responsible for such agencies in the geographical area in which it is located.

  Benefits are payable only if confinement in a **Hospital** or **Skilled Nursing Facility** would be required in the absence of home health care.

  The amount payable will not exceed the amount that would have been payable for such service or supply if the **Covered Person** had been confined in a **Hospital** as an in-patient.

  We will pay for one home health care visit per day up to 100 home health care visits per calendar year.

COMPREHENSIVE/MAJOR MEDICAL EXPENSE BENEFITS (C/MM) (Continued)

- **"Hospital Extras"** means all charges made by the **Hospital** for:
  - use of an emergency room; and
  - emergency treatment within:
    - 72 hours of an **Accidental Injury**;
    - 12 hours of the onset of **Illness**.

    The term "emergency" means
    - an accident which requires immediate treatment; or
    - a "life threatening" **Illness** which requires immediate treatment at a **Hospital**.
  - services and supplies other than Room and Board. This does not include Medical, Surgical, Dental and nursing services; and
  - if state law so requires, the processing and administration of blood and its components.

- **"Eligible Skilled Nursing Facility Confinement"** means confinement in a **Skilled Nursing Facility** which meets all of the requirements shown below. It must:
  - start within 7 days after the end of a **Hospital** confinement for which the patient was entitled to benefits under this **Booklet**. Such **Hospital** confinement must have lasted at least 3 days.
  - be due to the same condition that caused the **Hospital** confinement.
  - be necessary for the treatment of the same condition. This must be certified by the patient's **Doctor**.
  - not be chiefly for **Custodial Care**.

  At **our** request, the patient must give written medical evidence that the confinement meets these conditions. **We** can, at **our** own expense, require the patient to be examined by a **Doctor** of **our** choice.

- **"Hospice Care Covered Expenses"** means charges incurred for a **Hospice Care Program** to provide for physical, psychological, spiritual, or social needs of:
  - a **Covered Person** with a life expectancy of six months or less as certified by a **Doctor**; and
  - the **Covered Person's** family (his legal spouse, children, and parents).

  We will pay for **Hospice Care Covered Expenses** incurred by:
  - a **Covered Person** for:
    - up to 210 days of in-patient confinement in a Hospice; and
    - services rendered on an out-patient basis; and
  - up to 5 visits for bereavement expenses incurred by the **Covered Person's** family for supportive services provided to them before or after the death of the **Covered Person**.

  "Hospice Care Program" means a formal program directed by a **Doctor** to help care for a person with a life expectancy of six months or less. This program is through either:
  - a centrally-administered and nurse-coordinated program which:
    - provides a coherent system primarily of home care;
    - is available 24 hours a day, seven days a week; and
    - provides bereavement services;

  or
  - confinement in a Hospice.

  The **Hospice Care Program** must meet the standards set by the National Hospice Organization. If such Program is required by a state to be licensed, certified or registered, it must also meet that requirement to be considered a **Hospice Care Program**.

COMPREHENSIVE/MAJOR MEDICAL EXPENSE BENEFITS (C/MM) (Continued)

DEDUCTIBLE AMOUNT

Deductible Amount means the amount of **Covered Expenses** incurred by each **Covered Person** in each calendar year which, when accumulated in the order of their incurral, equal the Deductible Amount shown in the Table of Benefits.

Unless the Deductible Amount has been waived for the **Covered Expenses** concerned, no benefits are payable until the Deductible Amount has been satisfied.

With respect to the Deductible Amount, it is provided that:

- If:
  - you and at least one of your **Dependents**; or
  - two or more of your **Dependents**;

  are injured in the same accident only one Deductible Amount will be applied to all **Covered Expenses** which result from injuries sustained in the accident in the calendar year in which the accident occurred.

- the Deductible Amount in each calendar year will be reduced by the amount of **Covered Expenses**:
  - which were incurred in the last 3 months of the previous calendar year; but
  - for which no benefits were payable because these expenses were part of the Deductible Amount for that year.

- not more than the Family Deductible shown in the Table of Benefits will be applied in the form of Deductible Amounts against the **Covered Expenses** of you and all of your **Dependents** in any one calendar year.

PRESCRIPTION DRUG EXPENSE BENEFITS

Your prescription drug benefits are provided through a Preferred Pharmacy Program. This program uses a nationwide network of participating PCS pharmacies. Because network pharmacies have agreed to limit their charges to persons covered under the Preferred Pharmacy Program, your out-of-pocket costs will usually be lower if you use pharmacies in this network. You can obtain information about network pharmacies by calling TNE's toll-free Member Services number on your I.D. card.

Concurrent Drug Utilization Review

The Preferred Pharmacy Program has been designed to help ensure that you receive clinically and economically sound pharmaceutical care.

The network pharmacies are linked electronically to a computer system that contains information about drugs you have received while covered under this **Booklet**. Each time you present a prescription to be filled, this system is checked for:

- Drug interactions.
- Therapeutic duplications.
- Early refill and excessive use.
- Excessive/insufficient drug doses.
- Drug/disease, drug/age and drug/pregnancy interactions.

HOW TO USE THE PREFERRED PHARMACY PROGRAM

This program uses a network of pharmacies that are linked to an electronic claims system called RECAP. All participating network pharmacies have agreed to limit their charges to persons covered under the Preferred Pharmacy Program, which usually means lower out-of-pocket costs to you.

Because these pharmacies have access to your coverage information, they know exactly how much you should pay for each prescription. Processing claims electronically at the time of purchase eliminates claim forms, which means you don't have to wait for reimbursement for your prescription drugs.

Your ID card is the key to fast, convenient claims service and low out-of-pocket costs.

- Present your ID card when purchasing drugs at any network pharmacy.
- The pharmacy will ask you to sign a claim voucher, which lets them process your claim.
- Pay the pharmacist your co-pay for each prescription or prescription refill.

PRESCRIPTION DRUG EXPENSE BENEFITS (Continued)

Your co-pay is $5.00 for brand name drugs and $3.00 for generics.

Example: For a generic prescription that costs $20.00, you pay the $3.00 co-pay. **We** pay the remaining $17.00 directly to the pharmacist.

IF YOU DON'T HAVE YOUR ID CARD WITH YOU

If you don't have your ID card with you when you fill a prescription at a network pharmacy, you will pay the full price for the prescription and must file a claim to be reimbursed.

During the first 60 days you are covered for prescription drug benefits under this **Booklet**, if you don't use your ID card your reimbursement will be the retail price of the drug less your co-pay. PCS will send this reimbursement directly to you.

However, after you have been covered for 60 days, if you don't bring your ID card with you, your reimbursement will be the PCS negotiated pharmacy discount price less your co-pay. PCS will send this reimbursement directly to you. Your cost, which is retail price, is almost always greater than the PCS negotiated pharmacy discount price. You will not be reimbursed for the difference between retail price and PCS negotiated discount price. That's why it's important to bring your ID card with you when you purchase drugs.

IF YOU BUY A PRESCRIPTION DRUG AT A NON-NETWORK PHARMACY

If you purchase drugs at a non-network pharmacy, **we** pay 50% of the covered charges for drugs after the co-pay. Your co-pay is $5.00 for brand name drugs and $3.00 for generics.

If The Pharmacy Is A PCS Pharmacy

If you present your ID card at a non-network PCS pharmacy, you must pay the pharmacist your co-pay for each prescription or prescription refill, plus an amount equal to 50% of the remainder of the covered charges for the drug.

If The Pharmacy Is Not A PCS Pharmacy, Or If You Don't Have Your ID card With You

When you purchase drugs at a non-network pharmacy that is **not** a PCS pharmacy, or if the pharmacy **is** a PCS pharmacy but you do not bring your ID card, you must pay the full price of the prescription and file a claim to be reimbursed.

- Ask your **Employer** for a Prescription Drug Claim form.
- Complete this claim form, attach your prescription drug receipt, and mail it to the address printed on the form.
- PCS will send the reimbursement directly to you.

After the co-pay, the amount of your reimbursement will be 50% of the remainder of the covered charges for the prescription drug had you used a network pharmacy. If your pharmacy charges more for a prescription drug than a network pharmacy would charge, you will have to pay the difference.

PRESCRIPTION DRUG EXPENSE BENEFITS (Continued)

COVERED PRESCRIPTION DRUG EXPENSES

If you use a network pharmacy, covered expenses for prescription drugs are payable at 100% after your co-pay.

If you use a non-network pharmacy, covered expenses for prescription drugs are payable at 50% after your co-pay.

Covered expenses include charges for:

- Drugs and medicines that:
  - Require the written prescription of a **Doctor**; and
  - Are purchased from a licensed pharmacist or from a **Doctor** who is licensed to dispense drugs; and
  - Are required in the treatment of **Illness.**
- Insulin.

Covered expenses will be limited to the cost of a generic drug if a generic drug is available. However, the cost of a brand name drug will be considered a covered expense if a generic drug is not available, or if the **Doctor** writes DAW (Dispense as Written) on the prescription. If you request a brand name drug when a generic drug is available, and the **Doctor** has not written DAW on the prescription, then, in addition to the generic drug co-pay, you must pay the difference between the cost of the generic drug and the brand name drug.

MAIL ORDER PRESCRIPTION DRUG EXPENSE BENEFITS

QUALIFICATION FOR BENEFITS

If as a result of **Illness** a **Covered Person** incurs **Covered Mail Order Drug Expenses** which exceed the Co-Pay then **we** will pay the Mail Order Prescription Drug Benefits described below.

Benefits will be paid only if the Mail Order Prescription Drugs are:

- **Medically Necessary**; and
- received while the **Covered Person** is covered under this Benefit Provision; and
- recommended and prescribed by a **Doctor**.

MAIL ORDER PRESCRIPTION DRUG BENEFITS

We will pay benefits for all **Covered Mail Order Drug Expenses** which exceed the Co-Pay shown in the Table of Benefits.

The **Covered Person** must mail the prescription, a completed mail order drug form, and the Co-Pay to the Mail Order Vendor.

If the prescription is for a brand name drug but a generic equivalent is available, the **Covered Person** will be sent the generic drug unless the **Doctor** has written DAW (Dispense as Written) on the prescription.

DEFINITIONS

- **"Covered Mail Order Drug Expenses"** means actual charges (including expenses for home delivery) for up to a 90-day supply of:
  - **Prescription Maintenance Drugs**.

    This does not include oral contraceptives.
  - insulin.
- **"Prescription Maintenance Drugs"** means medication prescribed by a **Doctor** on an on-going basis.

CO-PAY

Co-Pay means the amount of **Covered Mail Order Drug Expenses** incurred by each **Covered Person** which equal the Co-Pay shown in the Table of Benefits.

The Co-Pay is applied against each purchase of a prescription or a refill. No benefits are payable until the Co-Pay has been satisfied.

DENTALCARE BENEFITS

QUALIFICATION FOR BENEFITS

If a **Covered Person** incurs **Covered Dental Expenses** which exceed the Deductible Amount, then **we** will pay the Dentalcare Benefits described below.

Benefits will be paid only if the **Covered Dental Expenses** are for treatment which is:

- incurred and, subject to any EXTENDED BENEFITS AFTER TERMINATION section of this **Booklet**, completed while the **Covered Person** is covered under this Benefit Provision; and
- rendered by:
  - for **Preventive and Basic Treatment**, a **Dentist, Doctor** or other qualified personnel under the direct supervision of a **Dentist** or **Doctor;**
  - for **Major Treatment**, a **Dentist** or **Doctor;**
  - for **Orthodontic Treatment**, a **Dentist** or **Orthodontist;**

  and
- rendered according to generally accepted dental practice; and
- consistent with the treatment rendered to prevent or correct dental disease, defect or injury by **Dentists** or **Doctors:**
  - who are in the same general area as the attending **Dentist** or **Doctor;** and
  - whose training and experience are similar to those of the attending **Dentist** or **Doctor.**

DENTALCARE BENEFITS

We will pay benefits for the **Usual and Customary Charges** for all **Covered Dental Expenses** which exceed the Deductible Amount at the Percentage shown in the Table of Benefits.

All **Covered Dental Expenses** are subject to the Maximum Amount and Limitations sections of this Benefit Provision.

DEFINITIONS

- **"Covered Dental Expenses"** means the **Usual and Customary Charges** incurred for the types of dental treatment described below when such treatment is rendered:
  - in case of **Preventive Treatment**, to prevent dental disease; and
  - for all other dental treatment, to correct dental disease, defect or injury.

DENTALCARE BENEFITS (Continued)

PREVENTIVE TREATMENT

- Oral examination.
- Prophylaxis (the cleaning and scaling of teeth).
- Bite-wing x-rays.
- Topical application of fluoride solutions but only for **Dependent** children under age 18.

NOTE: The services described above are each limited to twice in a calendar year but not more than once in any period of 5 consecutive months.

- Full-mouth series of x-rays once in each period of 36 consecutive months.
- Sealants for children.

BASIC TREATMENT

- Extractions and alveolectomy at the time of tooth extraction.
- Amalgam; silicate; acrylic; and composite restorations.
- Dental surgery.
- Diagnostic x-ray and laboratory procedures required in relation to dental surgery.
- General anesthesia required in relation to dental surgery.
- Treatment for relief of dental pain.
- Drugs and medicines which require a **Dentist's** written prescription. This includes the cost of medication and its administration when provided by injection in the **Dentist's** office.
- Space maintainers for missing primary teeth, and habit-breaking appliances.
- Consultations required by the attending **Dentist**.
- Relines and rebases to existing dentures.
- Endodontic Treatment.
- Periodontic Treatment.

MAJOR TREATMENT

- Provision of:
  - * crowns.
  - * fixed bridge restorations.
  - * removable partial or complete dentures. This includes denture replacement.
- Repairs to existing dentures.

ORTHODONTIC TREATMENT

Movement of the teeth by means of an active appliance to correct a handicapping occlusion as determined by **us**. Covered Expenses will be limited to treatment for your **Dependent** child who is at least 6 but not more than 18 years of age on the date treatment starts.

- The date an expense is incurred means:
  - for full or partial dentures, the date on which the final impression is made;
  - for fixed bridges, crowns, inlays and onlays, the date on which the teeth are prepared;
  - for root canal therapy, the date on which the pulp chamber is opened and explored to the apex;
  - for periodontal surgery, the date on which the surgery is actually performed;
  - for **Orthodontic Treatment**, the date on which the bands or appliances are inserted;
  - for any other treatment, the date on which the service is rendered.

DENTALCARE BENEFITS (Continued)

- The date on which treatment is completed means:
  - for full or partial dentures, the date on which the appliance is seated or inserted;
  - for fixed bridges, crowns, inlays and onlays, the date on which the restoration is cemented in place;
  - for root canal therapy, the date on which the pulp chamber is sealed;
  - for periodontal surgery, the date on which the surgery is actually performed;
  - for any other treatment, the date on which the service is rendered.

- **"Qualified Personnel"** means only persons qualified to perform the services rendered. This includes qualified dental assistants and dental hygienists.

- **"Treatment Plan"** means a written report which:
  - is prepared by the attending **Dentist**, **Doctor** or Orthodontist as a result of his examination of the patient; and
  - is in a form supplied or approved by **us**.

  The **Treatment Plan** must include all of the following:
  - a list of each procedure to be used during the treatment and its appropriate ADA Code.
  - the charge for each procedure.
  - the length of time the treatment will take.
  - any x-rays or other diagnostic material that will assist **us** in **our** review of the **Treatment Plan** such as:
    * full-mouth dental x-rays; and
    * cephalometric x-rays and the analysis of such x-rays; and
    * study models; and
    * completion of a questionnaire stating:
      - the degree of the overjet, overbite, crowding or open bite; and
      - whether the teeth are impacted in crossbite, or congenitally missing.

- **"Treatment Period"** means the period during which a planned course of treatment is to be rendered for the correction of any dental disease, defect or injury. This time period is estimated in the **Treatment Plan**.

- **"Course of Treatment"** means a period which:
  - starts on the date an expense is incurred as determined above; and
  - ends on the date the treatment is completed as determined above.

- **"Accidental Means"** means both the cause and the result of an **Accidental Injury:**
  - happen without intention or design; and
  - are unexpected, unusual and unforeseen.

TREATMENT PLAN PROVISION

You should submit a **Treatment Plan** to **us** for:

- a course of treatment which is expected to cost $300 or more; or

- a course of **Orthodontic Treatment;**

DENTALCARE BENEFITS (Continued)

before the date on which the treatment is to start. **We** can then advise you of the amounts payable under this Benefit Provision based on the **Treatment Plan.** If treatment does not start within 90 days of the date on which the **Treatment Plan** was received by **us,** then you should submit a new **Treatment Plan.**

The **Treatment Plan** will not be used as a prerequisite for the payment of benefits.

MAXIMUM AMOUNT

Preventive/Basic/Major Annual Maximum

The maximum amount payable for **Preventive, Basic and Major Treatment** for any one **Covered Person** in any one calendar year is the Annual Maximum shown in the Table of Benefits. However, if the **Covered Person** became covered on or after July 1 in any year, then the maximum amount payable from the date he became covered to the end of that calendar year will be the Adjusted Annual Maximum shown in the Table of Benefits.

Orthodontic Lifetime Maximum

The Maximum Amount payable for **Orthodontic Treatment** during the entire time you are covered in respect of the person for whom such Treatment is required is the Orthodontic Lifetime Maximum shown in the Table of Benefits. If:

- a person receives more than one such **Course of Treatment** during the time you are covered in respect of such person; and
- it can be clearly shown that any later **Course of Treatment** is not a part of the previous **Course of Treatment;**

then such person will be entitled to the Orthodontic Lifetime Maximum for each such **Course of Treatment.**

DEDUCTIBLE AMOUNT

Deductible Amount means the amount of **Covered Dental Expenses** incurred by each **Covered Person** which, when accumulated in the order of their incurral, equal the Deductible Amount shown in the Table of Benefits.

Unless the Deductible Amount has been waived for the **Covered Dental Expenses** concerned, no benefits are payable until the Deductible Amount has been satisfied.

The Calendar Year Deductible Amount shown in the Table of Benefits:

- will apply only to those **Covered Dental Expenses** incurred for the type of treatment to which the Calendar Year Deductible Amount applies (as shown in the Table of Benefits); and
- will be applied only once per person each calendar year.

DENTALCARE BENEFITS (Continued)

If:

- a **Treatment Plan** has been submitted; and
- the treatment:
  - is rendered in the treatment period estimated in the **Treatment Plan**; and
  - continues beyond the calendar year in which it was started;

then the Calendar Year Deductible Amount will be applied only once to all **Covered Dental Expenses**:

- for each course of treatment for which the expected cost is $300 or more; and
- for each course of **Orthodontic Treatment**.

Not more than the Family Deductible shown in the Table of Benefits will be applied in the form of Deductible Amounts against the **Covered Dental Expenses** incurred by you and all of your **Dependents** in any one calendar year.

The Calendar Year Deductible Amount will be waived for **Covered Dental Expenses** due solely to bodily injury sustained through external, violent and **Accidental Means**.

SPECIAL CONDITIONS APPLICABLE TO ORTHODONTIC TREATMENT BENEFITS

The **Covered Dental Expenses** for **Orthodontic Treatment** are considered to be incurred on a monthly basis. The first month starts on the date on which such treatment is first rendered. Each month after that starts on each monthly anniversary of the date treatment is first rendered during the course of the treatment period.

- SINGLE CHARGE BASIS - If the cost of **Orthodontic Treatment** does not include a separate charge for initial appliances, then the amount of each monthly **Covered Dental Expense** for such treatment is considered to be:
  - the total **Covered Dental Expense** for such treatment;

  divided by
  - the number of months of the treatment period.
- ITEMIZED CHARGE BASIS - If the cost of **Orthodontic Treatment** does include a separate charge for initial appliances, the amount of the monthly **Covered Dental Expense** for such treatment is considered to be:
  - for the first month of treatment, the lesser of:
    - the **Covered Dental Expense** for such appliances; and
    - 35% of the total **Covered Dental Expenses** for such treatment.
  - for each month of treatment after the first month:
    - the difference between:
      - the total **Covered Dental Expense**; and
      - the **Covered Dental Expense** determined for the first month of treatment;

    divided by
    - the number of months left in the treatment period.

DENTALCARE BENEFITS (Continued)

GENERAL CONDITIONS

- The **Covered Dental Expense** will be based on and benefits will be payable on the basis of the cost of services actually rendered and not on the basis of any **Treatment Plan** that may be submitted.

- Benefits for **Orthodontic Treatment** will be payable:
  - for the initial appliance, as soon as **we** approve the claim and the bands or appliances are inserted.
  - for all other treatment, at the end of each 3-month period. The amount of each such payment will be the sum of all benefits payable during such period.

VISIONCARE EXPENSE BENEFITS

QUALIFICATION FOR BENEFITS

If a **Covered Person** incurs **Covered Expenses,** then **we** will pay the Visioncare Benefits described below.

Benefits will be paid only if the **Covered Expenses** are:

- for services and supplies that are performed or prescribed by an **Ophthalmologist,** an **Optometrist** or a **Dispensing Optician;** and
- incurred while the **Covered Person** is covered under this Benefit Provision.

VISIONCARE EXPENSE BENEFITS

We will pay benefits for all **Covered Expenses** at the Percentage shown in the Table of Benefits.

DEFINITIONS

- **"Covered Expenses"** means the **Usual and Customary Charges** incurred for the services and supplies described below.
  - one **Complete Visual Analysis** up to the Visual Analysis Amount for each **Covered Person** in that period of 24 consecutive months that starts on the date on which you incur **Covered Expenses** for such person for a **Visual Analysis.**
  - one pair of spectacle lenses and frames up to the Spectacle Lens and Frame Amount for each **Covered Person** in that period of:
    * in respect of lenses, 24 consecutive months, and
    * in respect of frames, 24 consecutive months,

    that starts on the date on which you incur **Covered Expenses** for such person for lenses and/or frames but only when:
    * they are prescribed as a result of a **Visual Analysis** described above; and
    * such analysis shows that a change in prescription is needed.

    Any set of spectacle lenses and/or frames bought by a **Covered Person:**
    * after the initial set of spectacle lenses and/or frames; and
    * while he or she is covered under this Benefit Provision;

    will be considered to be **Covered Expenses,** but only if the coverage for that person under this Benefit Provision has been in force for at least
    * in respect of lenses, 24 consecutive months, and
    * in respect of frames, 24 consecutive months,

    since the last pair of spectacle lenses and/or frames was provided to him or her under this Benefit Provision.

VISIONCARE EXPENSE BENEFITS (Continued)

- contact lenses up to the Contact Lens For Special Conditions Amount during the entire time you are covered in respect of the person concerned but only when a **Visual Analysis** as described herein shows that:
  - * visual acuity can be improved to at least the 20/70 level in the better eye by contact lenses but not by eyeglasses; and
  - * a change in prescription is needed.
- when contact lenses are purchased in lieu of eyeglasses for cosmetic reasons, the **Covered Expense** is limited to the Contact Lens Amount applicable to Cosmetic Contact Lenses.

The limiting amounts referred to above are all shown in the Table of Benefits.

A **Covered Expense** is considered to be incurred on the date the service was rendered or the supply purchased.

- **"Complete Visual Analysis"** means refraction and eye examination. This includes:
  - case history; and
  - examination for:
    - * disease or pathological abnormalities of the eyes and lids;
    - * ranges of clear single vision; and
    - * balance and co-ordination of muscles for far seeing, near seeing and special working distances analysis; and
  - professional consultation.
- **"Dispensing Optician"** means a person who is qualified to manufacture and sell eyeglasses and/or contact lenses.
- **"Optometrist"** means a person who is licensed to practice optometry.
- **"Ophthalmologist"** means a **Doctor** who is licensed to practice ophthalmology.

C/MM BENEFIT LIMITATIONS

Under the C/MM Benefit Provision, no amount will be paid for:

- cosmetic surgery unless the operation is performed or the treatment is rendered to correct:
  - deformities that result from trauma, infection and other **Illness**; or
  - congenital defects that interfere with bodily but not psychological function; or
  - if state law so requires, any congenital defect of a newborn child.

  The term cosmetic surgery as used in this Benefit Provision means:
  - cosmetic surgery;
  - radiotherapy treatment administered for cosmetic reasons;
  - **Hospital** confinement or other services related to:
    * deformities that result from trauma, infection and other **Illness**; or
    * congenital defects that interfere with bodily but not psychological function.
- any services or supplies received as a result of experimental treatment or investigational treatment or procedure.
- examinations, check-ups or certifications which are not performed as a result of existing symptoms of **Illness**. This does not apply to **Preventive Care Covered Expenses** or **Well Newborn Care Covered Expenses**.
- eyeglasses, contact lenses, eye exams to assess visual acuity or the fitting of glasses and lenses.
- hearing aids or the fitting of hearing aids.
- dental services other than those listed under **Dental Covered Expenses**.
- services and supplies received for an **Illness** which is a result of war, declared or undeclared.
- drugs, medicines or insulin which are received as an out-patient (See Prescription Drug Expense Benefits) or which are not approved under the United States Food and Drug Act, or its successor.
- smoking cessation programs, including behavior modification or other support programs.
- **Doctor's** office visits for smoking cessation treatment.
- smoking cessation medications.

PRESCRIPTION DRUG EXPENSE BENEFIT LIMITATIONS

The following limitations apply to all prescription drugs you receive.

Benefits will be payable only if the covered prescription drugs are:

- Received while you or your **Dependent** is covered for these prescription drug benefits; and
- Recommended and prescribed by a **Doctor**.

No amount will be payable for:

- That part of a single purchase of any drug or medicine that exceeds a 34-day supply.
- More than one purchase of a drug, medicine or insulin during the dosage period recommended by the prescribing **Doctor**.
- Drugs, medicines, or insulin that:
  - Are not approved under the United States Food and Drug Act;
  - Are dispensed in a quantity or an amount in excess of that specified by the prescribing **Doctor**;
  - Are dispensed more than one year after the date on which the drug, medicine, or insulin was ordered by the prescribing **Doctor**;
  - Are consumed or used or administered while the covered person is confined to a **Hospital** or similar institution that has on its own premises a facility for dispensing pharmaceuticals.
- Therapeutic devices and appliances, immunization agents, biological serums, blood or blood plasma.
- The administration of drugs, medicines, or insulin.
- Over-the-counter drugs and supplies.
- Anti-obesity drugs and formulas.
- Allergy serums.
- Drugs for treatment of infertility.
- Smoking cessation medications.
- Oral contraceptives.
- **Experimental or Investigational** treatment or procedure.

MAIL ORDER PRESCRIPTION DRUG EXPENSE BENEFIT LIMITATIONS

Under the Mail Order Prescription Drug Expense Benefit Provision, no amount will be paid for:

- any drug or medicine which is not required in the treatment of **Illness**, including oral contraceptives.
- that part of a single purchase of a **Prescription Maintenance Drug** or insulin which exceeds a 90-day supply.
- more than one purchase of a drug, medicine or insulin during the dosage period recommended by the prescribing **Doctor**.
- drugs, medicines or insulin which:
  - are not approved under the United States Food and Drug Act, or its successor;
  - are dispensed in a quantity or an amount in excess of that specified by the prescribing **Doctor**;
  - are dispensed more than one year after the date on which such drug, medicine or insulin was ordered by the prescribing **Doctor**;
  - are consumed or used or administered while the person for whom they are prescribed is confined to an institution such as:
    - a **Hospital**;
    - a convalescent hospital;
    - a sanatorium;
    - **Skilled Nursing Facility**;
    - a nursing home; or
    - a rest home;

    which operates on its own premises or allows to be operated on its premises a facility for dispensing pharmaceuticals.
- therapeutic devices and appliances; immunization agents; biological sera; blood or blood plasma.
- the administration of drugs, medicines or insulin.
- **Experimental or Investigational** treatment or procedure.
- over-the-counter drugs and supplies.
- anti-obesity drugs and formulas.
- allergy serums.
- smoking cessation medications.
- drugs for treatment of infertility.

DENTALCARE BENEFIT LIMITATIONS

Under the Dentalcare Benefit Provision, no amount will be paid for:

- dental treatment:
  - which is covered under a government health plan or any other government plan; or
  - for which a government or government agency does not allow the payment of benefits; or
  - which are paid for or furnished by any government or government agency.

- dental treatment received from a dental or medical department which is maintained by:
  - your **Employer**; or
  - a mutual benefit association; or
  - labor union; or
  - trustee; or
  - similar type of group.

- dental treatment which is required as the result of war, declared or undeclared.

- broken appointments or the completion of claim forms.

- appliances which have been lost, mislaid or stolen.

- dental treatment which:
  - is cosmetic in nature; or
  - does not have general professional endorsement.

- **Experimental or Investigational** treatment or procedure.

- dental treatment or services rendered for:
  - dental treatment rendered for the correction of any congenital defect or developmental malformation which does not interfere with function; or
  - dietary planning for the control of dental caries; or
  - plaque control; or
  - oral hygiene instructions.

- initial installation of full or partial dentures or bridgework, including abutments, when they are installed to replace natural teeth extracted before the date on which the **Covered Person** last became covered under this Benefit Provision. However, if the appliance is required because a natural tooth was extracted after such date, then the expense of the appliance will be considered a **Covered Dental Expense**.

- replacement of existing full or partial dentures, bridgework or crowns, or the addition of teeth, inlays, onlays, crowns or gold restorations to such appliances when:
  - the existing appliance can be satisfactorily repaired and restored to use;
  - the replacement appliance is installed within 12 months of the date on which the **Covered Person** last became covered under this Benefit Provision;
  - the replacement appliance is installed within 5 years of the date of initial installation. If:
    * the replacement is made necessary by:
      - the extraction of functioning natural teeth; or
      - **Accidental Injury** (chewing injuries are not considered **Accidental Injuries**);

    and
    * the placement is completed within 12 months of such extraction or accident;

    then the expense of the replacement appliance will be considered a **Covered Dental Expense**.

DENTALCARE BENEFIT LIMITATIONS (Continued)

If an additional tooth or teeth are extracted and the existing appliance can be made serviceable by the addition of an extra tooth, then the expense for that part of the replacement appliance which replaces the teeth extracted after the effective date will be considered a **Covered Dental Expense.**

A replacement appliance will be considered a **Covered Dental Expense** if it:
- replaces an existing appliance which was temporarily installed after the date on which the **Covered Person** last became covered under this Benefit Provision; and
- is installed within 12 months after a temporary appliance was installed.

- customized procedures such as:
  - implants; or
  - precision or semi-precision attachments; or
  - over dentures or customized prosthesis; or
  - duplicate sets of dentures; or
  - facings on crowns or pontics and molars.

- crowns for teeth that are restorable by other means or for the purpose of periodontal splinting.

- expenses which are incurred:
  - before the effective date of the coverage under this Benefit Provision; or
  - after the date on which the coverage under this Benefit Provision terminates and is not replaced by another Benefit Provision issued by **us**; or
  - for Covered Dental Treatment which is completed after the date on which coverage under this Benefit Provision terminates and is not replaced by another Benefit Provision issued by **us.**

- that part of the charge for any procedure which is in excess of the charge for the least costly procedure which will, as determined by **us**, produce a professionally satisfactory result.

- that part of any **Covered Dental Expense** which constitutes a benefit paid or payable under any other Benefit Provision of this **Booklet** unless:
  - benefits are payable under both this Benefit Provision and the **C/MM** Benefit Provision; and
  - it is to the **Covered Person's** advantage to have benefits paid under this Benefit Provision rather than under the **C/MM** Benefit Provision.

- dental treatment for Temporomandibular Dysfunction (TMJ). For the purposes of this **Booklet**, TMJ is considered to mean craniofacial muscle disorders and temporomandibular disorders.

VISIONCARE EXPENSE BENEFIT LIMITATIONS

Under the Visioncare Expense Benefit Provision, no amount will be paid for:

- services and supplies received for an **Illness** which is a result of war, whether declared or undeclared.

- vision check-ups or screenings requested by:
  - your employer; or
  - a school; or
  - a government.

VISIONCARE EXPENSE BENEFIT LIMITATIONS (Continued)

- treatment received from a medical department maintained by:
  - an employer; or
  - a mutual benefit association; or
  - a labor union; or
  - a trustee; or
  - a similar type group.
- sunglasses, whether prescription type or otherwise. This includes tinted glasses with a tint other than #1 or #2.
- safety glasses.
- radial keratotomy.
- **Experimental or Investigational** treatment or procedure.
- orthoptics, vision training, or medical or surgical treatment of the eye.
- replacement of lenses or frames which have been lost, stolen or broken.

AD&D BENEFIT LIMITATIONS

Under the AD&D Benefit Provision, no benefits will be paid for any loss caused by or in connection with:

- suicide.
- intentionally self-inflicted injury.
- ptomaine or bacterial infections. This does not include a pyogenic infection which occurs with and through an accidental cut or wound.
- war or any act incident to war.
- any form of disease or **Illness** or physical or mental infirmity.
- the medical or surgical treatment of an **Illness**.

PB1R(b)NY

LONG TERM DISABILITY BENEFIT LIMITATIONS

Under the Long Term Disability Benefit Provision, no benefits will be paid for an **Illness:**

- which is the result of war, declared or undeclared.
- for which you are not continuously under the regular care and attendance of a Doctor.
- which is intentionally self-inflicted while sane or insane.
- which results from participating in a felony.

PA13R(d)NY

GENERAL LIMITATIONS

GENERAL LIMITATION (a)

General Limitation (a) applies to all **Health Benefits.**

No benefits will be paid for:

- an **Accidental Injury** that arises out of or in the course of any employment for pay or profit; or
- a sickness for which the person on whom the claim is presented is entitled to indemnity under the terms of any Worker's Compensation or similar law. This applies whether or not such person has declined participation under such law, except that this shall not apply with respect to proprietors, partners and executive corporate officer **Employees.**

GENERAL LIMITATION (b)

General Limitation (b) applies to all **Health Benefits.**

Where permitted by law, no benefits will be paid for that portion of the cost of services and supplies:

- which are provided by any government health plan under which the **Covered Person** is covered; or
- for which there would be no cost to the **Covered Person** if there were no coverage against such cost.

We are entitled to a refund of the amount of any benefits paid under this **Booklet** for services and supplies:

- not paid for by the **Covered Person**; or
- for which such person was reimbursed otherwise than under this **Booklet.**

GENERAL LIMITATIONS (Continued)

Benefits payable under this **Booklet** will not be reduced or denied because the **Covered Person** is entitled to benefits under a state sponsored medical assistance program, but those benefits will be paid to the state. Any amount **we** pay:

- will be considered benefits paid under this **Booklet**; and
- will constitute a full discharge of our liability to the extent of the payment.

Benefits payable under this **Booklet** that are in excess of those payable under the state program will be paid to you as otherwise provided in this **Booklet**.

GENERAL LIMITATION (c)

General Limitation (c) applies to all **Health Benefits**.

No benefits will be paid for services rendered by a member of the **Covered Person's** immediate family. This includes:

- your spouse, children, brothers, sisters, parents or grandparents; and
- your spouse's children, brothers, sisters, parents or grandparents.

PRE-EXISTING CONDITIONS LIMITATION

This section will not apply to you or a **Dependent** if:

- you apply for coverage for such person within 30 days of the date you first become eligible to cover such person; and
- at least 300 **Employees** are covered under the **Employer's** Plan.

C/MM BENEFITS

This section applies to the **C/MM** Benefit Provision.

This section will **not** apply to a child placed with you for adoption.

Under the Benefit Provision(s) to which this Limitation applies, no benefits will be paid for services and supplies received for a pre-existing condition unless they are received after the earlier of these dates:

- the last day of a 3 month period:
  - which ends on or after the date on which the **Covered Person** last became covered under such Benefit Provision; and
  - during which he received no services or supplies for the condition.

PRE-EXISTING CONDITIONS LIMITATION (Continued)

- the date on which such person's coverage under such Benefit Provision has been in force for 12 consecutive months. This 12-month period starts on the date his coverage last became effective.

A pre-existing condition means an **Illness** for which a **Covered Person** received services or supplies during the 3 months before the date on which his coverage last became effective under such Benefit Provision.

LONG TERM DISABILITY BENEFITS

No benefits will be paid for a disability caused or contributed to by a pre-existing condition unless the disability occurs after the date on which your insurance under this **Booklet** has been in force for 12 consecutive months. This 12-month period starts on the date your insurance last became effective.

A pre-existing condition means an **Illness** for which you either saw a **Doctor** or received services or supplies during the 90 days before the date on which your insurance last became effective under this **Booklet**.

PA13R(e)

DENTALCARE LATE APPLICATION LIMITATION

If a **Covered Person's** coverage takes effect more than 31 days after the date on which he becomes eligible to be covered, then no benefits will be paid for:

- any **Basic** or **Major Treatment** which is rendered within 12 months of the effective date of such coverage; and
- **Orthodontic Treatment** which is rendered within 24 months of the effective date of such coverage;

unless the treatment is required as a result of an **Accidental Injury** to natural teeth after the date on which the coverage took effect.

PLAN MAXIMUM AMOUNT

This section applies only to the **C/MM** Benefit Provision.

Under the Benefit Provision(s) to which this Plan Maximum applies, the maximum amount payable for any one person for all expenses during the entire time such person is covered under this **Booklet** will be the Maximum Lifetime Benefit. The Maximum Lifetime Benefit includes expenses which are incurred for mental or nervous conditions and substance abuse. The Maximum Lifetime Benefit is shown in the Table of Benefits.

MISCELLANEOUS PROVISIONS

In this Plan:

- contract months and contract years start from the effective date.
- all requests, notices, proofs and applications must be made to the **Employer**.
- words of the masculine gender include the feminine.

GENERAL PROVISIONS

NOTICE OF CLAIM

We must receive written notice of claim within 20 days after the date of the loss or as soon after that as is reasonably possible. Notice can be given at the Benefit Payments Office listed on the Claim Report. Notice should include:

- your name; and
- the name of your **Employer**.

CLAIM FORMS

When **we** receive notice of claim, **we** will send the claimant forms for filing proof of loss. If these forms are not given to the claimant within 15 days, the claimant can meet the proof of loss requirements by giving **us** a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss section.

GENERAL PROVISIONS (Continued)

PROOFS OF LOSS

Written proof of loss must be given within 90 days after the loss.

If it is not reasonably possible to give written proof in the time required, **we** will not reduce or deny the claim as long as the proof is filed as soon as reasonably possible.

TIME OF PAYMENT OF CLAIMS

Benefits payable under this **Booklet** will be paid as soon as written proof of loss is received.

PAYMENT OF CLAIMS

Benefits will be paid to you, if living. If not, benefits will be paid to your estate. If any benefit is payable to:

- your estate; or
- a person who cannot give a valid release;

then **we** can pay up to $1,000 to any relative **we** consider to be entitled to such payment. **We** will be discharged to the extent of such payment made in good faith.

You may request in writing that payments under this **Booklet** be made directly to the person providing the services.

LEGAL ACTIONS

You may bring a legal action to recover under the Plan. Such legal action may be brought:

- no sooner than 60 days; and
- no later than 3 years;

after the time written proof of loss is required to be given under the terms of the Plan.

PHYSICAL EXAMINATIONS AND AUTOPSY

We, at **our** own expense, have the right to have the person for whom a claim is pending examined as often as reasonably necessary. **We** may also have an autopsy performed unless prohibited by law.

BENEFIT PAYMENTS TO A REPRESENTATIVE OF A MINOR

In the case of a minor child who otherwise qualifies as a **Dependent** under this **Booklet**, if the child designates a representative, then **we** must pay benefits on behalf of that child to his or her representative, even if that person is not covered under this **Booklet**. The person must:

- submit written notice that he or she is the representative of the child on whose behalf the claim is made; and
- provide evidence that the person qualifies to be paid the benefits.

PROVISION FOR TRANSFER GROUPS

HEALTH BENEFITS

- Applicability of this Provision - This Provision applies only to a **Covered Person** for whom coverage:
  - started as of the Plan Effective Date; and
  - terminated at the same time under the provisions of a group health plan issued to the **Employer** by another **Insurance Carrier.**

- Special Benefits for a Pre-existing Condition - To qualify for these special benefits the **Covered Person** must not be eligible for benefits under the prior plan because of a pre-existing condition or other contractual limitation or exclusion of benefits for expenses incurred after termination of that plan.

  The amount of such benefits will be the lesser of:
  - the amount that would have been paid under the other Insurance Carrier's group health plan if it had stayed in force; and
  - the amount payable under this **Booklet.**

- Deductible and Break Point Credits - For the calendar year in which the transfer in coverage takes place:
  - the Deductible Amount under the **C/MM** Benefit Provision will be reduced by the amount of any expenses:
    * which were incurred:
      - during the current calendar year; or
      - in the last 3 months of the previous calendar year;

      by the **Covered Person** while he was covered under the prior plan; but
    * for which no benefits were payable because these expenses formed part of a deductible under such other plan.
  - the Individual Break Point under the **C/MM** Benefit Provision, if any, will be reduced by the amount of any expenses:
    * which were incurred:
      - during the current calendar year; or
      - in the last 3 months of the previous calendar year;

      by the **Covered Person** while he was covered under the prior plan; but
    * to which a Percentage of less than 100% was applied in calculating benefits under such other plan.

DENTALCARE BENEFITS

This Provision applies only to a **Covered Person** whose coverage:

- started on the effective date of this Benefit Provision; and

- terminated on the day before such date under a group dental plan sponsored by the **Employer** or issued to the **Employer** by an **Insurance Carrier** (the prior plan).

PROVISION FOR TRANSFER GROUPS (Continued)

If such **Covered Person** incurs expenses for the installation of an initial prosthodontic appliance and such expenses are not covered:

- under the prior plan solely because such plan terminated; or
- under this Benefit Provision solely because the installation was done to replace a natural tooth which was missing before he became covered under this Benefit Provision;

then such expenses will be covered as provided under this Benefit Provision unless such installation was done to replace a natural tooth which was missing before he became covered under the prior plan.

If such **Covered Person** incurs expenses for the replacement of an existing prosthodontic appliance and such expenses are not covered:

- under the prior plan solely because such plan terminated; or
- under this Benefit Provision solely because the replacement appliance was installed before the end of the 12-month period following the date he became covered under this Benefit Provision;

then such expenses will be covered as provided under this Benefit Provision unless such replacement was done before he became covered under the previous carrier's plan.

Benefits will be limited to the lesser of:

- the expense that would have been covered under the prior plan if it had stayed in force; and
- the expense that is covered under this Benefit Provision.

In no event will benefits be paid for expenses that are covered under any section in the previous carrier's plan relating to extension of benefits after plan termination.

If a Deductible Amount is shown in the Table of Benefits, it will be reduced in the calendar year in which the **Employer** transfers his coverage to this **Booklet**. The amount of the reduction will be the amount of the dental deductible the **Covered Person** had satisfied in that calendar year under the prior plan.

LONG TERM DISABILITY BENEFITS

This provision applies only if this **Booklet** has been issued in replacement of a group long term disability plan providing similar benefits (the replaced policy). It will allow certain **Employees** to avoid loss of coverage solely because of a transfer of insurance carriers. It will override the **Actively at Work** requirement and the PRE-EXISTING CONDITIONS LIMITATION for those **Employees** as described below.

For Employees Not Actively at Work on the Group Policy Effective Date

Benefits may be payable under this **Booklet** if:

- just prior to the Group Policy Effective Date you were validly covered under the replaced policy; but
- you would not otherwise be covered under this **Booklet** solely because you were not **Actively at Work.**

The benefit payable will be that which would have been paid by the prior carrier under the replaced policy had coverage remained in force, less any benefit for which the prior carrier is liable.

PROVISION FOR TRANSFER GROUPS (Continued)

NOTE: An **Employee** will be considered **Actively at Work** on the Group Policy Effective Date if he is:

- on vacation; or
- on an approved leave of absence; or
- absent from **Work** due to an **Illness** which has not caused him to be **Totally Disabled.**

For Employees who have a Pre-Existing Condition on the Group Policy Effective Date

Benefits may be payable under this **Booklet** if:

- just prior to the Group Policy Effective Date you were validly covered under the replaced policy; and
- you were **Actively at Work** on the Group Policy Effective Date; but
- you would not otherwise be covered under this **Booklet** solely because of the PRE-EXISTING CONDITIONS LIMITATION.

The amount of such benefits will be the lesser of:

- the amount that would have been paid under the replaced policy had coverage remained in force; and
- the amount that would have been paid under this **Booklet** if it did not have a PRE-EXISTING CONDITIONS LIMITATION.

The length of time for which benefits are payable for any **Illness** will be the lesser of:

- the Maximum Benefit Period, including limited benefit periods for specified **Illnesses** under this **Booklet**; and
- the length of time benefits would have been payable for such **Illness** under the replaced policy.

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If the period during which no benefits are payable under the PRE-EXISTING CONDITIONS LIMITATION had been partially satisfied under the replaced policy, then such period will be reduced by the number of consecutive months that you were covered under the replaced policy just prior to the Group Policy Effective Date.

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HEALTH MAINTENANCE ORGANIZATIONS (HMO)

You can choose to be covered for **Health Benefits** under either:

- this **Plan**; or
- a Health Maintenance Organization (HMO) chosen by your **Employer.**

TRANSFERRING FROM ONE PLAN TO ANOTHER

You can choose either plan when you first become eligible for coverage under your **Employer's Plan** or when you first transfer to the area serviced by the HMO. After that you can transfer:

- From this **Plan** to the HMO plan at any time as long as the transfer is allowed under the HMO plan. However, you are then no longer eligible:
  - for extended benefits after the termination of coverage under this **Plan.**
  - to exercise the conversion privilege under this **Plan.**
- From the HMO plan to this **Plan:**
  - during any **Open Enrollment Period:**
  - if the HMO terminates; or
  - within 31 days of the date you move out of the area serviced by the HMO and as a result can no longer participate under that plan.

The **Open Enrollment Period** is AUGUST 1 to AUGUST 31. If you transfer to the **Plan** during an **Open Enrollment Period**, then your coverage will start on the first day following the end of the **Open Enrollment Period.**

WAIVER OF WAITING PERIOD

When you transfer under any of the above conditions, you do not have to go through any waiting period under this **Plan** nor will your coverage be restricted because of the health status of yourself or your **Dependents.** No **Proof of Good Health** will be required.

You can also transfer from the HMO plan to this **Plan** at any other time but then you must provide **Proof of Good Health** for yourself and each of your **Dependents** at your own expense. You will also have to satisfy any waiting periods and your coverage will be subject to any limitations based on **Pre-Existing Conditions.**

PROVISION FOR ADOPTIVE CHILDREN

Coverage will be provided under this **Booklet** for any child placed with you for adoption. The coverage will be subject to the following conditions:

FOR CONTRIBUTORY PLANS

If you must contribute to the cost of your **Dependent's** coverage, then you must:

- apply for the coverage in writing; and
- make the required contribution.

PROVISION FOR ADOPTIVE CHILDREN (Continued)

If you do so:

- within 31 days of the child's date of placement, then coverage for the child will start:
  - for an adoptive newborn, from the moment of birth if the child's date of placement is within 31 days after the birth of the child; and
  - for any other adoptive child, from the date of placement.
- more than 31 days from the date of placement, then the coverage for the adoptive child will start on the date on which **we** approve **Proof of Good Health** for that child. **Proof of Good Health** must be given at your own expense.

FOR NON-CONTRIBUTORY PLANS

If you do not have to contribute to the cost of your **Dependents'** coverage, then coverage for the adoptive child will start:

- for an adoptive newborn, from the moment of birth if the child's date of placement is within 31 days after the birth of the child; and
- for any other adoptive child, from the date of placement.

DATE OF PLACEMENT

"Date of placement" means the date you assume and retain a legal obligation for total or partial support of a child in anticipation of the adoption of that child.

PRE-EXISTING CONDITIONS LIMITATION

Any Pre-Existing Conditions Limitation described elsewhere in this **Booklet** will **not** be applied to the coverage of a child placed with you for adoption.

TERMINATION OF COVERAGE FOR ADOPTIVE CHILDREN

Your adoptive **Dependent** child's coverage will end on the earlier of these dates:

- the date on which the petition for adoption is dismissed or denied.
- the date on which the placement is disrupted prior to legal adoption and the child is removed from placement.

PROVISION FOR MENTAL/NERVOUS BENEFITS

The benefits which are described in this Provision will be subject to all other parts of this **Booklet** except as specifically stated in this Provision.

MENTAL/NERVOUS COVERED EXPENSES

Mental/Nervous Covered Expenses means **Usual and Customary Charges** incurred by a **Covered Person** for treatment of mental and nervous conditions. Such treatment must be **Medically Necessary** and will be limited to:

- inpatient treatment during confinement in a **Hospital.**
- outpatient treatment:
  - in a **Hospital**; or
  - by a **Doctor**; or
  - by a Social Worker who is:
    * appropriate and qualified to treat the patient's condition as determined by us; and
    * licensed or certified by the department responsible for such licensing or certification in the geographic area in which the treatment is given.

As used herein, the term "Hospital" will include any institution that provides mental and nervous treatment and is licensed or certified by the Department responsible for such licensing or certification in the geographical area in which the treatment is given.

AMOUNTS PAYABLE

Subject to the Limitations and Maximums set out below, if the **Covered Person** incurs Mental/Nervous Covered Expenses, then benefits will be payable in the same way as for any other **Illness.**

LIMITATIONS AND MAXIMUMS

Benefits will be payable:

- for inpatient treatment, up to a maximum of 30 days during any one calendar year.
- for outpatient treatment, at 50% after the calendar year deductible, up to a maximum of 52 visits for any one person in any one calendar year.
- for outpatient Crisis Intervention Services, up to a maximum of 3 visits in any one calendar year.

NOTE: Benefits for Crisis Intervention Services will be payable only if a licensed mental health care provider whose services are covered under the **Plan** certifies that:

- the visit was the result of a psychiatric emergency; and
- immediate observation, care and treatment was necessary to prevent serious harm to the **Covered Person** or to others.

PROVISION FOR OUT-PATIENT SUBSTANCE ABUSE BENEFITS

The benefits which are described in this Provision will be subject to all other parts of this **Booklet** except as specifically stated in this Provision.

SUBSTANCE ABUSE COVERED EXPENSES

Substance Abuse Covered Expenses means **Usual and Customary Charges** incurred by a **Covered Person** for treatment of alcoholism or substance abuse. Such treatment must be **Medically Necessary** and will be limited to out-patient treatment in a **Hospital** or by a **Doctor.** As used herein, the term **"Hospital"** will include any institution that provides alcoholism treatment programs which are certified by the New York Division of Alcoholism and Alcohol Abuse.

AMOUNTS PAYABLE

Subject to the Limitations and Maximums set out below, if the **Covered Person** incurs Substance Abuse Covered Expenses then benefits will be payable in the same way as for any other **Illness.**

LIMITATIONS AND MAXIMUMS

Benefits will be payable for up to 60 visits in any one calendar year, of which up to 20 visits may be for family members.

PROVISION FOR IN-PATIENT SUBSTANCE ABUSE BENEFITS

The benefits which are described in this Provision will be subject to all other parts of this **Booklet** except as specifically stated in this Provision.

SUBSTANCE ABUSE COVERED EXPENSES

Substance Abuse Covered Expenses means **Usual and Customary Charges** incurred by a **Covered Person** for treatment of alcoholism or substance abuse. Such treatment must be **Medically Necessary** and will be limited to in-patient treatment during confinement in a **Hospital.** As used herein, the term **"Hospital"** will include any institution that provides alcoholism treatment programs which are certified by the New York Division of Alcoholism and Alcohol Abuse.

AMOUNTS PAYABLE

Subject to the Limitations and Maximums set out below, if the **Covered Person** incurs Substance Abuse Covered Expenses then benefits will be payable in the same way as for any other **Illness.**

LIMITATIONS AND MAXIMUMS

Benefits will be payable for up to:

- 7 days of active treatment in any one calendar for detoxification treatment as a consequence of chronic alcoholism.
- 30 days in any one calendar for rehabilitation services.

PROVISION FOR PRIMARY AND PREVENTIVE CARE FOR CHILDREN

The benefits which are described in this Provision will be subject to all other parts of this **Booklet** except as specifically stated in this Provision.

Benefits will be payable under this **Booklet** for Preventive and Primary Care of Children subject to the following:

- Coverage will only be provided for covered person **Dependent** children up to age 19 for an initial hospital check-up and and well child visits.
- Care provided must be consistent with the Guidelines for Health Supervision of Children and Youth, as adopted by the American Academy of Pediatrics and will include:
  - A history;
  - Physical examination;
  - Developmental assessment;
  - Anticipatory guidance; and
  - Appropriate immunizations against diptheria, pertussis, tetanus, polio, measles, rubella, mumps. hemophilus influenza type B and Hepatitis B which meet the standards approved by the United States Public Health Service.
- Benefits will be payable in the same way as any **Illness**, except that they will not be subject to any deductible or coinsurance provisions. Benefits will be payable first on the basis described in this Provision and then on the basis described in the **Booklet** for **Preventive Care Covered Expenses, Routine Physical Examination Covered Expenses** or **Well Newborn Care Covered Expenses.**

PROVISION FOR COVERED PERSONS WHO HAVE REACHED AGE 65 (TEFRA/DEFRA/COBRA)

This Provision applies to you if you are an active **Employee** who has attained age 65. It also applies to your spouse if you are an active **Employee** of any age and your spouse has attained age 65.

Upon attainment of age 65, you or your spouse will continue to be eligible for the benefits provided under this **Booklet**. Benefits will be payable as otherwise provided under this **Booklet** except that such benefits will not be reduced by any **Medicare** benefits to which you or your spouse is entitled solely on account of age. This means that for the purposes of the COB section, the benefits payable under **Medicare** will be determined after the benefits under this **Booklet** are determined.

If:

- you do not wish to have the benefits of this **Booklet** payable before benefits are payable under **Medicare**; and
- you would rather have **Medicare** be the primary plan of benefits;

you may contact your Plan Administrator.

NOTE: If you elect **Medicare** as the primary payer of benefits, no benefits will be payable under this **Booklet**. See your Plan Administrator for details.

PROVISION FOR COVERED PERSONS WHO ARE ELIGIBLE FOR MEDICARE ON ACCOUNT OF DISABILITY (OBRA)

This Provision applies to you if you as an active **Employee** or one of your eligible **Dependents** qualify for benefits under **Medicare** on account of disability. Benefits payable under this **Booklet** will not be reduced by any **Medicare** benefits to which you or your eligible **Dependents** are entitled solely on account of disability. This means that for the purposes of the COB section, the benefits payable under **Medicare** will be determined after the benefits provided under this **Booklet** are determined.

PROVISION FOR COVERED PERSONS ELIGIBLE FOR MEDICARE ON ACCOUNT OF END STAGE RENAL DISEASE (ESRD)

This Provision applies to you if you are an active **Employee** and you or one of your eligible **Dependents** qualifies for benefits under **Medicare** on account of ESRD. Benefits payable under this **Booklet** will not be reduced by any **Medicare** benefits to which you or your eligible **Dependent** is entitled solely on account of ESRD for up to the first 30 consecutive months of treatment. This means that for the purposes of the COB section, the benefits payable under **Medicare** will be determined after the benefits provided under this **Booklet** are determined.

For the purpose of this section the period of 30 consecutive months of treatment begins with the earlier of the following:

- the month in which you or your eligible **Dependent** initiates a regular course of renal dialysis.
- in the case of an individual who receives a kidney transplant, the first month in which the individual could become entitled to **Medicare** if he filed a timely application. That is, the earliest of the following:
  - the month in which the transplant is performed;
  - the month in which the individual is admitted to the **Hospital** in anticipation of a transplant that is performed within the next two months;
  - the second month before the month the transplant is performed, if performed more than 2 months after admission.

If you or your eligible **Dependent** initiates renal dialysis but does not begin training for self-dialysis during the first 3 months of dialysis, then you or your eligible **Dependent** will be subject to a 3-month waiting period by **Medicare**. No benefits will be payable under **Medicare** during this time.

MEDICARE REDUCTION FOR RETIRED EMPLOYEES

If you are a **Retired Employee** age 65 or over, then any **Health Benefits** payable under this **Booklet** for you and your **Medicare** age spouse after you reach the applicable age shown above will be directly reduced by the amounts payable for the same expenses under Parts A and B of **Medicare**. This means **Medicare** will pay their benefits first and will be known as the primary payer of benefits. You and your **Medicare** age spouse will be considered to be enrolled under both Parts A and B of **Medicare** whether or not you are actually so enrolled.

PROVISION FOR MILITARY RESERVISTS

This provision applies to Military Reservists who are called-up to active duty for a period of more than 30 days.

CONTINUATION OF COVERAGE FOR EMPLOYEES AND DEPENDENTS

Coverage for yourself and your eligible **Dependents** will be continued for as long as you are on active duty.

TERMINATION OF CONTINUED BENEFITS

At the end of your period of active duty, any continued benefits will terminate automatically on the earlier of:

- the date of your return to work with your **Employer**;
- the end of the time period specified in the Uniformed Services Employment & Re-employment Rights Act.

RETURN TO WORK PROVISION

If you:

- are honorably discharged; and
- return to **Work** with your **Employer** within the time period specified in the Uniformed Services Employment & Re-employment Rights Act;

then on the date you return to work, coverage for you and your eligible **Dependents** will be on the same basis as that provided for any other active **Employee** and his **Dependents** on that date.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

The following exceptions will apply to benefits provided under this Plan as described in the provisions of this **Booklet**. Anything specifically stated in this Provision:

- will be subject to all other parts of this **Booklet** except as specifically stated in this Provision; and
- is for the purpose of compliance with Federal law.

In the event that any limitation periods or waiting periods described in this Provision exceed those required by state law, the shorter period will apply.

As used in this Provision, any reference to **Dependent** applies only if **Dependent** coverage for any Medical, Prescription Drug, Dental and Vision Benefits is provided under this Plan.

START OF COVERAGE

For any Medical, Prescription Drug, Dental and Vision Benefits, any requirement that:

- an **Employee** be **Actively at Work**;
- a **Dependent** not be **Totally Disabled**;

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (Continued)

for coverage to become effective is hereby deleted.

IF YOU DON'T APPLY FOR COVERAGE WHEN FIRST ELIGIBLE

You or your **Dependent** will be considered a late applicant under this Plan if:

- You have to make a contribution and don't apply for coverage within 31 days of the date you become eligible; or
- You do not have to make a contribution but elect not to have coverage;

and you later want coverage for that person.

For any Medical, Prescription Drug, Dental and Vision benefits, a person:

- May apply for coverage only during an Open Enrollment Period. Your Plan Administrator can tell you when the Open Enrollment Period begins and ends.

  Coverage for a late applicant who applies for coverage during the Open Enrollment Period will begin on the first day of the month following the close of the Open Enrollment period.
- Will be subject to special limitations for pre-existing conditions for Medical benefits.
- Will be subject to any late applicant limitations for Dental Benefits.

Proof of Good Health is not required.

For all other benefits, coverage for a late applicant will begin on the date TNE approves **Proof of Good Health.**

EXCEPTIONS TO THE DEFINITION OF LATE APPLICANT - SPECIAL ENROLLEE

A person (you or your **Dependent**) will **not** be considered a late applicant if:

- You did not apply for coverage for the person within 31 days of the date you became eligible to do so because the person was covered under another health insurance plan or arrangement (other plan); and
- Coverage under the other plan was lost as a result of:
  - Exhausting the maximum period of COBRA coverage; or
  - Loss of eligibility for the other plan's coverage due to legal separation, divorce or death of a spouse; or
  - Termination of employment or reduction in the number of hours of employment; or
  - Termination of the employer's contribution for the other plan's coverage.

  You must have stated in writing that the other health coverage was the reason you declined coverage under this Plan, but only if the **Employer** required such a statement and notified you of the consequences of the requirement when you declined coverage.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (Continued)

- You did not apply to cover your spouse or a **Dependent** child within 31 days of the date you became eligible to do so and later are required by a court order to provide coverage for that person.

- You did not apply to cover yourself or an eligible **Dependent** within 31 days of the date you became eligible to do so and later experience a change in family status because you acquire a **Dependent** through marriage, birth or adoption. In this case, you may apply to cover yourself and any of your eligible **Dependents**.

If you apply within 31 days of the date:

- Coverage is lost under the other plan, as described above, coverage will start on the day after coverage is lost under the other plan.

- A court order was issued, coverage will start on the date specified in the court order.

- You acquire a new **Dependent**, coverage will start:
  - In the case of marriage, on the first day of the calendar month beginning after the date your completed application for coverage is received by TNE.
  - In the case of birth or adoption, on the date of birth, adoption or placement for adoption.

Medical benefits will be subject to special limitations for pre-existing conditions. See the Pre-Existing Conditions Limitation described below.

PRE-EXISTING CONDITIONS LIMITATION

A pre-existing condition is an **Illness** or any related condition for which you or your **Dependent** received services, supplies or medication during the lesser of:

- any period shown in the "PRE-EXISTING CONDITIONS LIMITATION" for Medical benefits; and

- a 6-month period;

before the enrollment date for you or your **Dependent** under this Plan.

A pre-existing condition is not:

- a pregnancy existing on the enrollment date; or

- genetic information.

In no event will benefits be excluded for services, supplies or medication solely because they were for treatment of a pre-existing condition if received on or after:

- for a late applicant, the date which is 18 months after the enrollment date;

- for any other person, the earlier of:
  - the date shown in the "PRE-EXISTING CONDITIONS LIMITATION" for Medical benefits; and
  - the date which is 12 months after the enrollment date.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (Continued)

"Enrollment date" means:

- for an **Employee** who applies for coverage for himself or herself during the 31-day period after first becoming eligible to do so (the **Employee's** initial application period), the first day of the **Employee's Service** with the **Employer.**
- for an eligible **Dependent** for whom application for coverage is made during the 31-day period after the **Employee's** initial application period, the first day of the **Employee's Service** with the **Employer.**
- for a late applicant or special enrollee (as described above) or for any newly acquired **Dependent**, the date the person becomes covered under this **Plan.**

PORTABILITY OF COVERAGE

A person (you or your **Dependent**) will receive credit toward satisfaction of the Pre-Existing Conditions Limitation for the time he or she was covered under another health plan, but only if:

- your **Service** begins after the effective date of this Plan; and
- the person was covered, under another health plan that meets the definition of "Creditable Coverage", within the 62-day period just before you or your **Dependent's** enrollment date under this Plan.

Any eligibility waiting period that the person is required to satisfy under this Plan will not be taken into consideration in determining the 62-day period.

If the person was covered for a period of time under Creditable Coverage that is:

- greater than or equal to the time periods referred to in the Pre-Existing Conditions Limitation described in this section, then the Pre-Existing Conditions Limitation periods will not apply to the person.
- less than the time periods referred to in the Pre-Existing Conditions Limitation described in this section, then the Pre-Existing Conditions Limitation periods will be reduced by the number of consecutive days that the person was covered under Creditable Coverage.

However, for a child who became covered under Creditable Coverage within 31 days of birth, the Pre-Existing Conditions Limitation periods will not apply regardless of how long the child was covered under Creditable Coverage.

"Creditable Coverage" is defined as coverage under a group health plan, individual health insurance coverage, **Medicare,** Medicaid or other public health plans, CHAMPUS, a medical program of the Indian Health Service or of a tribal organization or the Peace Corps, state health benefit risk pools and the Federal Employee Health Benefit Plan (FEHBP).

It is your responsibility to provide information about Creditable Coverage in order for the Pre-Existing Conditions Limitation under this Plan to be reduced or waived.

TNE ADDRESS

The address of TNE is 8505 E. Orchard Road, Englewood, CO 80111.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (Continued)

ERISA RIGHTS

If you have any questions about the "Statement of ERISA Rights" included in the "ERISA GENERAL INFORMATION" or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

LIFE AND ACCIDENTAL DEATH, DISMEMBERMENT AND LOSS OF SIGHT (AD&D) BENEFITS

This **Booklet** is issued to your **Employer** as evidence of the coverage he has applied for under Group Policy Number **450223GL** issued

to

BUS ASSOCIATES, INC.
(the Group Policyholder)

by

New England Mutual Life Insurance Company at its Administrative Services Offices in Englewood, Colorado
(the Company)

New England Mutual Life Insurance Company certifies that:

- it has issued a Group Policy to the Policyholder; and
- your **Employer** has applied for and has become insured for the Plan of benefits described in this **Booklet**.

This **Booklet** becomes your Certificate of Insurance only if:

- you are eligible for coverage (see WHO'S ELIGIBLE section);
- you become insured by filling out the appropriate application forms and by being approved for coverage by the Company; and
- you stay insured.

(TNE)L1

AMOUNT OF INSURANCE

- Your Amount of Insurance is the amount shown for your Insurance Class in the Schedule of Insurance.

- Basic Insurance - If your Insurance Class does not allow Excess Insurance, then you can only have Basic Insurance. The factors which determine your amount may change. If so, your amount will change on the date on which the factors changed.

- Excess Insurance - If your Insurance Class allows Excess Insurance, then you can apply for Excess Insurance. Your Excess Insurance will take effect on the date on which **we** approve your **Proof of Good Health**. If you are accepted for Excess Insurance, then:
  - your amount will be your Total Insurance;
  - increases will be subject to **Proof of Good Health**; and
  - decreases will take place as for Basic Insurance.

- You must be at **Work** for your insurance to increase. If you are not, your insurance will not increase until the date on which you return to **Work**.

- Your Amount of Insurance will be reduced by the amount of any policy issued to you under the Conversion Privilege section of this **Booklet** or any other group policy issued to your **Employer**.

L5NY

- If the amount of Basic Insurance:
  - under this **Booklet**; or
  - under any policy which this **Booklet** replaced or replaces;

  is or was increased by amendment and you were eligible to apply for Excess Insurance prior to the date of such increase but:
  - did not apply for such Excess; or
  - applied for such Excess but:
    * did not become insured for the Excess because **we** did not approve the **Proof of Good Health** you submitted; or
    * became insured for such Excess on a substandard basis;

  then you will be insured for the amount of Basic Insurance which was in effect on the day before such increase and not for the increased amount. You will not later be insured for a greater amount, regardless of any amendments, until the date on which the **we** approve your **Proof of Good Health**. Such proof must be furnished without cost to us. Any amount of Basic Insurance or Excess Insurance for which you may become insured under the terms of this provision will be subject to any reductions due to age or retirement contained in the Schedule of Insurance. L5a

DISABILITY BENEFIT

WAIVER OF PREMIUM

Premiums do not have to be paid for your insurance if you become **Totally Disabled** and satisfy all of the following:

- you became disabled while insured under this **Booklet** and prior to age 60;

- your disability is continuous and is due to bodily injury or sickness;

DISABILITY BENEFIT (Continued)

- you are unable to **Work** for pay or profit in any job for which you are or may become suited by reason of education, training or experience;
- you stay **Totally Disabled** for 9 consecutive months;
- premiums for your insurance cease to be paid under the TERMINATION section;
- proof of your **Total Disability** is sent to **our** Administrative Services Offices in Englewood, Colorado. Proof must be received within 12 months of the start of the disability; and
- you surrender any individual policy issued on or after the date on which you became disabled under the CONVERSION PRIVILEGE section of:
  - this **Booklet**; or
  - any policy issued by **us** which:
    * replaces the Group Policy; or
    * the Group Policy replaced.

  All premiums paid for the individual policy after you have been **Totally Disabled** for 9 months will be returned.

  During the 9 month period, proceeds will be paid under either the Group Policy or the individual policy but not under both.

DEATH BENEFIT

If you die, proof of your death must be sent to **our** Administrative Services Offices in Englewood, Colorado. This **Booklet** need not be in force when you die. On receipt of proof, **we** will pay the **Proceeds**, but only if:

- your insurance was continued under the Waiver of Premium section; and (TNE)L9
- you had provided proof of your **Total Disability**:
  - within 12 months after you first became **Totally Disabled**; and
  - after that, at **our** request; and
- your **Total Disability** continued without a break until your death.

The **Proceeds** will be calculated according to the Schedule of Insurance in effect on the date you became disabled. Any termination or reduction due to age or retirement in that Schedule will still apply.

GENERAL PROVISIONS

You will no longer be eligible for this BENEFIT if:

- you fail to give proof of your **Total Disability** as required; or
- you cease to be **Totally Disabled**.

If all or part of your insurance terminates due to:

DISABILITY BENEFIT (Continued)

- failure to give required proof;
- your ceasing to be **Totally Disabled**; or
- age or retirement reductions or terminations;

then you may use the CONVERSION PRIVILEGE as if your **Service** had terminated under the TERMINATION section, but only if:

- you apply for the individual policy within the time specified in the CONVERSION PRIVILEGE section; and
- you do not become insured under this **Booklet** again.

CHANGE OF BENEFICIARY

The terms of the BENEFICIARY section will also apply to this BENEFIT. L8a

DEATH BENEFIT

If you die, proof of your death must be sent to **our** Administrative Services Offices in Englewood, Colorado. On receipt, subject to all other sections of this **Booklet**, **we** will pay the **Proceeds** to your beneficiary.

(TNE)L10

BENEFICIARY

This section applies to both life insurance and Accidental Death, Dismemberment and Loss of Sight (AD&D) benefits.

You may name a beneficiary when you apply for insurance. Unless legally restricted, you can change the beneficiary.

Naming or changing a beneficiary must be:

- in writing;
- signed by you; and
- filed with your Plan Administrator.

If a named beneficiary dies before you, that part of the **Proceeds** which such beneficiary would have received will be paid to any remaining named beneficiaries who survive you. This will not be the case if:

BENEFICIARY (Continued)

- you have specified otherwise on your application; or
- the applicable state law does not allow this.

Subject to the applicable state law, if no named beneficiary survives you or if you have not named a beneficiary, the **Proceeds** will be paid:

- to your surviving spouse; if none, then
- to your surviving child or children; if none, then
- to your surviving parent or parents; if none, then
- to your surviving brothers or sisters; if none, then
- to your estate.

Unless you have specified otherwise, when there are two or more named beneficiaries the **Proceeds** will be divided in equal shares. L10

FACILITY OF PAYMENT

We have the right:

- to deduct an amount from the **Proceeds**; and
- to pay such amount to anyone who has incurred expenses for your last illness or death.

The total amount of all such payments will not exceed $500.

We will be discharged to the extent of any such payments made in good faith. L11

METHODS OF PAYMENT

The life insurance will be paid to the beneficiary. Prior to your death, you may elect to have your life insurance paid to your beneficiary in any manner to which **we** agree.

If you do not elect an optional payment method prior to your death, then after your death the beneficiary may elect to have the life insurance paid to him or her in any manner to which **we** agree.

Payments will not be made more than once a year unless each payment is at least $25.

GENERAL PROVISIONS

ASSIGNMENT

You may absolutely assign your life insurance. This assignment includes your right to:

- use the CONVERSION PRIVILEGE; and
- change the BENEFICIARY.

However, you cannot assign your insurance as collateral security.

We are not responsible for the validity or effect of any assignment. **We** will not recognize an assignment until the original has been noted at **our** Administrative Services Offices in Englewood, Colorado. (TNE)L12

NON-PARTICIPATING

The Group Policy is not entitled to share in **our** surplus earnings. L12

INCONTESTABILITY

After the Group Policy has been in force for 2 years, its validity can only be contested due to non-payment of premiums. During the first 2 years your insurance is in force, only a written statement signed by you can be used to contest the validity of your insurance. After your insurance has been in force for 2 years during your lifetime, no statement made by you can be used to contest the validity of your insurance. L12

AGE

Before benefits are paid, **we** must receive proof of your age. An adjustment will be made if:

- your age has been misstated; and
- a different premium rate would have been charged for your true age.

The difference between the premiums actually paid, and those which should have been paid, will be calculated. The difference will be paid:

- by your **Employer** to **us**, if your age was understated; and
- by **us** to your **Employer**, if your age was overstated. L12

ACCELERATED BENEFIT

Any Accelerated Benefit that you receive may be treated as taxable income and may affect your eligibility for Medicaid or other government benefits or entitlements. You should consult your personal tax and/or legal advisor before you apply for an Accelerated Benefit.

If you are terminally ill, you may apply to receive a portion of your life insurance as an "Accelerated Benefit". In order to do this, you must be covered under this **Booklet** and you must give **us** satisfactory proof of having a "Qualifying Medical Condition".

"Qualifying Medical Condition" means you are terminally ill, with a life expectancy of 12 months or less. In considering a request for an Accelerated Benefit, **we**, at our expense, may require that you be examined by a **Doctor** of **our** choice.

The Accelerated Benefit is being provided at no additional cost to you or your **Employer**.

No adjustment will be made to your life insurance premium rate in the event an Accelerated Benefit is paid.

TO APPLY FOR AN ACCELERATED BENEFIT

To apply for an Accelerated Benefit you must:

- contact your **Employer** for the appropriate application form; and
- send your application to **us** along with a statement from your **Doctor** certifying that you have a Qualifying Medical Condition.

  For purposes of this benefit, your **Doctor** cannot be:
  - yourself; or
  - a person who is part of your immediate family (your parent, spouse, sibling or child); or
  - a person who lives with you.

The request for an Accelerated Benefit must be made by the terminally ill **Insured Person**. However, if he or she is legally incapacitated or a minor child, the request must be made by a person with legal authority to act on the **Insured Person's** behalf.

AMOUNT OF ACCELERATED BENEFIT

You may request an Accelerated Benefit of up to 50% of the amount of your life insurance to a maximum of $100,000. The minimum Accelerated Benefit may not be less than the lower of 25% of your life insurance or $50,000.00.

The amount of the Accelerated Benefit available to you will be based on the amount of life insurance coverage provided to you by **us** under this **Booklet** when you request the Accelerated Benefit.

If your life insurance is scheduled to reduce within 12 months of the date you apply for the Accelerated Benefit, then the amount of the Accelerated Benefit will be based on the reduced amount.

The Accelerated Benefit will be paid to you in a lump sum. You may only request an Accelerated Benefit one time while covered by **us**. If you recover from your Qualifying Medical Condition after receiving an Accelerated Benefit, **we** will not ask you for a refund of the Accelerated Benefit. However, your amount of life insurance will be reduced as described below.

ACCELERATED BENEFIT (Continued)

THE EFFECT OF AN ACCELERATED BENEFIT ON LIFE INSURANCE

After payment of the Accelerated Benefit, the amount of your life insurance coverage under this **Booklet** will be reduced by the amount of the Accelerated Benefit. If the Accelerated Benefit amount is equal to or exceeds the amount of life insurance in force at the time of your death, no additional amounts of life insurance will be payable upon your death.

If you want to convert your life insurance as described in the Eligibility section of your booklet (see "Conversion of Life Insurance Benefits"), then the amount of life insurance available for conversion may be affected by the amount of any Accelerated Benefit paid. An amount paid as an Accelerated Benefit will not be available for conversion. Any other reduction or termination of your life insurance coverage may be eligible for conversion.

DISABILITY WAIVER OF PREMIUM

If you are approved for an Accelerated Benefit you may also be approved for disability waiver of premium. If you are already on disability waiver of premium when approved for an Accelerated Benefit, you will continue on premium waiver.

LIMITATIONS

No Accelerated Benefit will be paid if:

- All or part of your insurance must be paid to your children or your spouse or former spouse as part of a court approved divorce decree, separate maintenance agreement, or property settlement agreement.
- You are married and live in a community property state, unless you provide us with a signed statement from your spouse consenting to payment of the Accelerated Benefit.
- You have made an assignment of all of your life insurance, unless you provide **us** with a signed statement from your assignee consenting to payment of the Accelerated Benefit.
- You have filed for bankruptcy, unless you provide **us** with written approval from the bankruptcy court for payment of the Accelerated Benefit.
- You have previously received an Accelerated Benefit while covered under this **Booklet.**

If you have assigned part of your insurance to any person, business or organization, the Accelerated Benefit can only be paid on the portion of your life insurance that is not assigned.

ACCIDENTAL DEATH, DISMEMBERMENT AND LOSS OF SIGHT (AD&D) BENEFITS

QUALIFICATION FOR BENEFITS

If you sustain bodily injury which:

- is caused solely by accidental means; and
- results in one or more of the losses set forth in the Table of Losses; and
- is sustained while the **Employee** is insured under this Benefit Provision;

then, **we** will pay the AD&D Benefits described below. PB1R(a)

AD&D BENEFITS

We will pay all or part of the Principal Sum according to the Table of Losses below. The Principal Sum is shown in the Schedule of Insurance. Only one of the amounts, the largest, will be paid for all injuries which result from any one accident.

Payment will be made only if the loss:

- occurs within 90 days after the accident; and
- is a direct result of the accident; and
- is unrelated to any other cause. PB1R(a)

TABLE OF LOSSES

For loss of:	
Life	The Principal Sum
Both Hands or Both Feet or Sight of Both Eyes	The Principal Sum
One Hand and One Foot	The Principal Sum
One Hand or One Foot and Sight of One Eye	The Principal Sum
One Hand or One Foot	1/2 Principal Sum
Sight of One Eye	1/2 Principal Sum

PB1R(a)

Loss of hands and feet means permanent dismemberment by severance through or above the wrist or ankle joints. Loss of sight means total and permanent loss of sight beyond remedy by surgical or other means. PB1R(b)

DISABILITY BENEFIT

The Disability Benefits described in this **Booklet** will not apply to AD&D Benefits. PB1R(c)

GENERAL PROVISIONS (AD&D)

Note: The following GENERAL PROVISIONS apply to Accidental Death, Dismemberment and Loss of Sight (AD&D) Benefits only:

CLAIM FORMS

When **we** receive notice of claim, **we** will send the claimant forms for filing proof of loss. If these forms are not given to the claimant within 15 days, the claimant can meet the proof of loss requirements by giving **us** a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss section. H9

PROOFS OF LOSS

Written proof of loss must be given within 90 days after the loss.

If it is not reasonably possible to give written proof in the time required, **we** will not reduce or deny the claim as long as the proof is filed as soon as reasonably possible. H9NY

LEGAL ACTIONS

You may bring a legal action to recover under the **Booklet**. Such legal action may be brought:

- no sooner than 60 days; and
- no later than 3 years;

after the time written proof of loss is required to be given under the terms of the **Booklet**. H9a

PHYSICAL EXAMINATIONS AND AUTOPSY

We, at **our** own expense, have the right to have the person for whom a claim is pending examined as often as reasonably necessary. **We** may also have an autopsy performed unless prohibited by law. H9b

CONFORMITY WITH STATUTES

This **Booklet** is amended to comply with the minimum requirements of the state in which this **Booklet** is issued. H9c

LONG TERM DISABILITY INCOME INSURANCE BENEFITS

This **Booklet** is issued to your **Employer** as evidence of the coverage he has applied for under Group Policy Number **450223GDH** issued

to

BUS ASSOCIATES, INC.
(the Group Policyholder)

by

New England Mutual Life Insurance Company at its Administrative Services Offices in Englewood, Colorado
(the Company)

New England Mutual Life Insurance Company certifies that:

- it has issued a Group Policy to the Group Policyholder; and
- your **Employer** has applied for and has become insured for the Plan of benefits described in this **Booklet**.

This **Booklet** becomes your Certificate of Insurance only if:

- you are eligible for coverage (see WHO'S ELIGIBLE section);
- you become insured by filling out the appropriate application forms and by being approved for coverage by the Company; and
- you stay insured.

(TNE)LTD1

QUALIFICATION FOR BENEFITS

We will pay benefits to you for a **Total Disability** which:

- starts while you are insured under this **Booklet**; and
- lasts for at least the length of the **Elimination Period.**

Such benefits will:

- start on the first day after the end of the **Elimination Period.**
- end on the earliest of these dates:
  - the date on which the **Total Disability** ends;
  - the date on which you fail to give proof of your disability as required;
  - the last day of the Maximum Benefit Period shown in the Table of Insurance.

TEMPORARY RECOVERY DURING ELIMINATION PERIOD

If:

- you are **Totally Disabled** and temporarily recover so that you can return to **Work** for a limited period not to exceed the Maximum Number of Temporary Recovery Days during the **Elimination Period** shown in the Table of Insurance; and
- again become **Totally Disabled**;

then **we** will not consider the **Elimination Period** to be interrupted. However, when you again become **Totally Disabled** your disability must be due to the same or related causes as the initial disability.

Any days of return to **Work** will not be used to satisfy the **Elimination Period**.

DEFINITION OF TOTAL DISABILITY

"Total Disability" means being under the regular care of a **Doctor** and prevented by **Illness:**

(1) during the **Elimination Period** (shown in the Table of Insurance) and the next 24 months of any **Period of Disability**, from performing each of the material duties of your regular occupation.

(2) for any period after that, from working for pay, profit, or gain at any job for which you are suited by:
  - education;
  - training; or
  - experience.

DEFINITION OF TOTAL DISABILITY (Continued)

NOTE: If you are working but your **illness** prevents you from earning more than:

- 80% of your pre-disability **Monthly Earnings** during the period described in (1) above; or
- 50% of your pre-disability **Monthly Earnings** during the period described in (2) above;

then you will still be considered **Totally Disabled** provided you are under the regular care of a **Doctor.**

AMOUNT OF INSURANCE

- Your Amount of Insurance is the amount shown for your Insurance Class in the Table of Insurance.
- The factors which determine your Amount of Insurance may change. If so, your amount will change on the date on which the factors change. No change will be made in your Amount of Insurance during a **Period of Disability.**
- You must be at **Work** for your Amount of Insurance to increase. If you are not, your Amount of Insurance will not increase until the date on which you return to **Work.** LTDS

AMOUNT PAYABLE

The amount of the monthly benefit to which you are entitled is:

- your Amount of Insurance (shown in the Table of Insurance) in effect on the date the **Period of Disability** starts;

reduced by

- the amounts determined in the INCOME FROM OTHER SOURCES section. PA13R(o)

NOTE: If the sum of:

- your Amount Payable; and
- the amounts determined in the INCOME FROM OTHER SOURCES section; and
- the monthly amount of any pay you may receive from any employer which is not considered INCOME FROM OTHER SOURCES;

exceeds 100% of your **Monthly Earnings,** then your monthly benefit will be reduced by the amount of such excess.

NOTE: **We** will pay one-thirtieth of the amount determined under this section for each day of any **Period of Disability** which is less than a full month.

MINIMUM MONTHLY BENEFIT

Unless benefits are being adjusted as a result of an overpayment, the amount of monthly benefit will not be less than the Minimum Monthly Benefit (shown in the Table of Insurance).

INCOME FROM OTHER SOURCES

The total of all amounts described below will be considered INCOME FROM OTHER SOURCES:

- the monthly amount of any benefits to which you or your spouse or your children are entitled under the disability or retirement provisions of:
  - the Federal Social Security Act of the United States.
  - the Canada Pension Plan.
  - the Quebec Pension Plan.
  - any similar government plan or act. This does not include benefits received on account of military service or any benefits excluded by state law.
- the monthly amount of any indemnity to which you are entitled under any Worker's Compensation or similar law.
- 50% of the monthly amount of any pay you may receive from any employer during a **Period of Disability**, including sick pay, salary continuance or vacation pay.
- the monthly amount of any indemnity to which you are entitled under any group insurance plan, other than:
  - group credit insurance; or
  - group mortgage disability insurance.
- the monthly amount of any indemnity to which you are entitled under any state unemployment compensation disability benefit law or state disability income benefit law.
- the monthly amount of indemnity for loss of time to which you are entitled under any mandatory No-Fault Auto Insurance Law or similar law which requires or provides such coverage for an accidental injury. PA13R(b)NY
- the monthly amount of disability or retirement benefits from any Retirement Plan to which your **Employer** made contributions, except:
  - any return of your own contribution will not be considered;
  - any amount which you could have received upon termination of employment without being disabled or retired will not be considered.

INCOME FROM OTHER SOURCES (Continued)

Note: Retirement Plan means a plan which provides retirement benefits to **Employees** and which is not funded entirely by **Employee** contributions. It does not include:

- a profit sharing plan;
- a thrift plan;
- an individual retirement account (IRA);
- a tax sheltered annuity (TSA);
- a stock ownership plan;
- a deferred compensation plan;
- a 401(k) plan
- a Keogh (HR-10) plan with respect to partners.

LUMP SUM PAYMENTS

If you receive any INCOME FROM OTHER SOURCES in a lump sum, then **we** will prorate that lump sum on a monthly basis over a time period determined by **us**.

ESTIMATION OF INCOME FROM OTHER SOURCES

If you are entitled to but have not yet received income from any of the sources described in the INCOME FROM OTHER SOURCES section, **we** may estimate the monthly amount of such income. This estimated monthly amount will be used to determine benefits under this **Booklet**.

If you are entitled to receive but choose not to receive income from any of the sources described in the INCOME FROM OTHER SOURCES section, such amount will not be used to estimate your income under this section.

We will not estimate the amount of such income if you have applied for but have been denied such income.

FREEZE ON INCOME FROM OTHER SOURCES

If the amount of INCOME FROM OTHER SOURCES increases after payment of benefits has begun, the amount of such increase will not be used to reduce benefits. This applies only through the end of the existing **Period of Disability**. Such increases **will** be used to reduce benefits for the next **Period of Disability**, if any.

PA13R(c)

NOTE: The amount payable **will** be reduced by any increase in your Social Security benefit which is due to your acquiring another dependent or any increases in the amount of pay you may receive from any employer during the existing **Period of Disability**.

ADJUSTMENT OF BENEFITS

If, after payment of your Long Term Disability benefit begins, **we** find that the amount of your INCOME FROM OTHER SOURCES is different than what **we** first determined, then **we** will adjust the amount of your benefit as follows:

- If **we** have underpaid benefits, **we** will pay you the amount of any such underpayment.
- If **we** have overpaid benefits, **we** will have the right to recover the amount of such overpayment by deducting the amount from any future benefit payments. The Minimum Monthly Benefit will not apply during any period in which an overpayment is being recovered.

DRUG/ALCOHOL LIMITATION

In any one **Period of Disability**, benefits will be limited to 24 months for any **illness** which is due to drug or alcohol abuse or the use of any hallucinogenic. However, if at the end of such 24-month period you are confined as an in-patient in a **Hospital**, we will continue to pay benefits until you are no longer so confined.

MENTAL ILLNESS LIMITATION

In any one **Period of Disability**, benefits will be limited to 24 months for any **illness** which is due to any mental or nervous disorder. However, if at the end of such 24-month period you are confined as an in-patient in a **Hospital, we** will continue to pay benefits until you are no longer so confined.

SURVIVOR BENEFITS

If you die while you are entitled to Long Term Disability Benefits, then **we** will continue paying monthly benefits for up to 3 months. **We** will pay such benefits to:

- your spouse, if living, otherwise;
- your unmarried children under age 21.

If none of the above survive you, then no benefits will be payable.

If at the time of your death there is an overpayment outstanding, **we** will reduce the amount of the survivor benefits by the amount of such overpayment.

GENERAL PROVISIONS

WAIVER OF PREMIUM

No premium is payable for your insurance during any period for which a monthly benefit is payable under this **Booklet**.

AGE

Before benefits are paid, **we** may request proof of your age. An adjustment will be made if:

- your age has been misstated; and
- a different premium rate would have been charged for your true age.

The difference between the premiums actually paid, and those which should have been paid, will be calculated. The difference will be paid:

- by your **Employer** to us, if your age was understated; and
- by **us** to your **Employer**, if your age was overstated.

INCONTESTABILITY

After this Group Policy has been in force for 2 years, its validity can only be contested due to non-payment of premiums. During the first 2 years your insurance is in force, only a written statement signed by you can be used to contest the validity of your insurance. After your insurance has been in force for 2 years during your lifetime, no statement made by you can be used to contest the validity of your insurance. LTD8NY

NON-PARTICIPATING

The Group Policy is not entitled to share in our surplus earnings. LTD8

NOTICE OF CLAIM

We must receive written notice of claim within 20 days after your **Total Disability** starts or as soon after that as is reasonably possible. Notice can be given at our Administrative Services Offices in Englewood, Colorado or to one of our authorized agents. Notice should include:

- your name; and
- the group policy number. (TNE)LTD8a

CLAIM FORMS

When **we** receive notice of claim, **we** will send you the forms for filing proof of loss. If these forms are not given to you within 15 days, then you can meet the proof of loss requirements by giving **us** a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss section.

GENERAL PROVISIONS (Continued)

PROOFS OF LOSS

Written proof of loss must be given to **us** within 90 days after the end of the **Elimination Period.**

If it is not reasonably possible to give written proof in the time required, **we** will not reduce or deny the claim as long as the proof is filed as soon as reasonably possible. LTD8aNY

TIME OF PAYMENT OF CLAIMS

Benefits will be paid each month during the period for which **we** are liable. Any balance remaining unpaid on termination of the period for which **we** are liable will be paid as soon as written proof of loss is received. LTD8a

LEGAL ACTIONS

No legal action may be brought to recover on this **Booklet** within 60 days after written proof of loss has been given as required by this **Booklet.** No such action may be brought after 3 years from the time written proof of loss is required to be given.

CONFORMITY WITH STATUTES

This **Booklet** is amended to comply with the minimum requirements of the state in which this **Booklet** is issued.

PHYSICAL EXAMINATIONS

We, at our own expense, have the right to have the person for whom benefits may be payable examined as often as reasonably necessary. LTD8b

FLEXIBLE BENEFITS ACCOUNT

Flexible Benefits Account
For Employees of

BUS ASSOCIATES, INC.

This **Booklet** becomes your Proof of Coverage only if:

- you are eligible for coverage (see Who's Eligible section);
- you become covered by filling out the Flexible Benefits Account Enrollment Form; and
- you stay covered.

EFFECTIVE DATE

The effective date of this Plan is JANUARY 1, 1998.

OPTIONS AVAILABLE

The PREMIUM EXPENSE CONVERSION ACCOUNT option is available to you under this Plan.

The benefits provided under the PREMIUM EXPENSE CONVERSION ACCOUNT option are described in the BENEFIT PROVISION section of this Plan.

PLAN YEAR DEFINITION

"Plan Year" means

- for the first **Plan Year**, that period beginning on JANUARY 1, 1998 and ending on DECEMBER 31, 1998, and
- for any **Plan Year** thereafter, that period beginning on JANUARY 1 and ending on DECEMBER 31.

Unless specifically defined herein, the meaning of all other terms used in this Plan will be the same as those used in the group health policy/plan sponsored by the **Employer**.

APPLICATION TO PARTICIPATE/ELECTIONS

The Annual Election Period means the 60-day period just prior to any **Plan Year**. If you are eligible to participate in this Plan you may, during the Annual Election Period, complete a Flexible Benefits Account Enrollment Form. Your **Employer's** Plan Administrator will furnish such form to you. The election made on such form will be irrevocable until the end of the applicable **Plan Year** unless you are entitled to change your benefit elections as described below.

If you are an eligible new **Employee**, who is employed during a **Plan Year**, you may elect to participate in this Plan provided you do so within 31 days of the date you first become eligible. In no event may an **Employee's** participation begin on a date prior to the date he makes an election.

CHANGE OF ELECTIONS

You may change a benefit election after a **Plan Year** has commenced and make new elections for the rest of such **Plan Year** if such changes are due to the following:

- marriage;
- divorce;
- death of spouse or child;
- birth or adoption of child; or
- the switching from part-time to full-time employment status or from full-time to part-time status by you or your spouse;
- termination or commencement of employment of your spouse;
- the taking of an unpaid leave of absence by you or your spouse;
- increase or decrease in cost of benefits; or
- significant changes in your health coverage or in your spouse's coverage which is attributable to your spouse's employment.

BENEFIT PROVISIONS

PREMIUM EXPENSE CONVERSION ACCOUNT

If you elect this option, your salary will be reduced by an amount equal to the amount you must contribute for you and your **Dependent's** medical, dental and vision coverage under your **Employer's** group policy/plan.

This option terminates automatically on termination of your employment.

EXAMINATION OF RECORDS

The Plan Administrator will make available to each **Employee** such records as pertain to the **Employee**, for examination at reasonable times during normal business hours.

AMENDMENT OR TERMINATION OF PLAN

Your **Employer**, at any time or from time to time, may amend any or all of the provisions of the Plan without your consent. No amendment will have the effect of reducing any of your benefit election in effect at the time of such amendment, unless such amendment is made to comply with federal law or local statute or regulations.

Your **Employer** reserves the right to terminate the Plan, in whole or in part, at any time.

MISCELLANEOUS PROVISIONS

NON-ALIENATION OF BENEFITS

No benefit, right or interest of any person hereunder will be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, seizure, attachment or legal, equitable or other process or be liable for, or subject to, the debts, liabilities or other obligations of such person, except as otherwise required by law.

MISCELLANEOUS PROVISIONS (Continued)

LIMITATION ON EMPLOYEE RIGHTS

Nothing appearing in or done pursuant to the Plan will be held or construed:

- to give any person any legal or equitable right against your **Employer** or the Plan Administrator, except as expressly provided herein or provided by law; or
- to create a contract of employment with any **Employee,** to obligate your **Employer** to continue the service of any **Employee** or to affect or modify his or her terms of employment in any way.

OTHER SALARY-RELATED PLANS

It is not intended that any other salary-related **Employee** benefit plans that are maintained or sponsored by your **Employer** will be affected by this Plan. Any contributions or benefits under such other plans with respect to you will, to the extent permitted by law, be based on your compensation from your **Employer**, including any amounts by which your salary or wages may be reduced.

STATE OF JURISDICTION

This Plan is governed by the Internal Revenue Code and the regulations issued thereunder (as they might be amended from time to time).